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Vol. II. }

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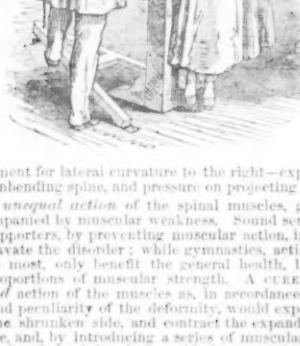
1. LATERAL CURVATURE OF THE SPINE

Sample movement for lateral curvature to the right—expanding contracted (left) side, unbending spine, and pressure on projecting (right) shoulder.

Is caused by *unequal action* of the spinal muscles, generally (but not always) accompanied by muscular weakness. Sound sense and experience prove that supporters, by preventing muscular action, increase the weakness and aggravate the disorder; while gymnastics, acting on all muscles alike, can, at most, only benefit the general health, but cannot correct relative disproportions of muscular strength. A CURE would consist in such *regulated* action of the muscles as, in accordance with the anatomy of the body and peculiarity of the deformity, would expand the contracted muscles on the shrunken side, and contract the expanded muscles on the projecting side, and, by introducing a series of muscular actions *opposite* that which produced the deformity, would thus reestablish a uniform and harmonious action of antagonist muscles, when the deformity would disappear. (See cuts.)



Sample movement for lateral curvature to the right—contracting the expanded (right) side, unbending spine, and pressure on projecting (right) shoulder.

2. PARALYSIS

Is produced by a suspension of the nervous stimulus to the muscles by some cause affecting the nervous centres. The shock may have passed off, or the clot in the brain may have become absorbed, and the paralysis may still, wholly or in part, remain, because it requires a special effort to re-establish the connexion of brain and muscles. In ordinary exercise, the *un*affected muscles perform the most of the action, while the paralyzed ones perform the least.

This process should be reversed, and the paralyzed muscles made to act while the unaffected parts are at rest. The nerves must be re-educated to perform their functions, by sustained, gentle, well-directed, and repeated efforts of the will on the affected muscles, till the latent power is developed to be an efficient one.

Sample movement for paralysis,—concentrating the *will* on the extensors of the leg, while the rest of the body is at rest.

3. ANGULAR CURVATURE OF THE SPINE

(Pott's disease) consists of actual disease of the bodies of the vertebræ, with loss of substance at the point of disease. The weakened *spine* needs support, but the *muscles* should not be confined.

"Spinal assistant" for *angular* curvature (Pott's disease), provided with hinges (*f, f, f, f, G, G*), which allow the spinal muscles to act.

An original instrument (see cut) is used, so constructed with several hinges which bend backward but not forward, that while the spine is supported and the diseased surfaces relieved from pressure, the muscles of the back are encouraged to act (instead of being prevented, as in all other instruments), and thus the muscles themselves are made the efficient part of the instrument acting over the curvature to reduce it. There is no confinement; it is very adjustable; the pressure is increased and diminished at pleasure, and it is worn with the greatest comfort. The importance of thus developing the spinal muscle, contiguous to the diseased point, cannot be overestimated, as results show.

4. THE TREATMENT

(which is based on the Swedish system of Ling), is purely scientific and physiological, and though it is not claimed to be applicable to every case, in many it is very clearly indicated; as, in dyspepsia and constipation, by acting on the stomach and bowels, to give tone to the digestive organs; in consumption, by expanding the chest, distributing the circulation, and increasing the aerating process; in diseases incident to women, by giving general vigor to the muscles, especially of the back, hips, and abdomen, relieving the downward tendency of the organs, and increasing the peripheric circulation, to relieve uterine and other internal congestions.

AND IN ALL CASES the treatment is done, not by the patient's unaided efforts, but by trained assistants, nicely adapting each movement to the strength and needs of each patient, precisely as prescribed by the physician to secure the desired local or general results. There is nothing like "rubbing," "gymnastics," or calisthenics" about it, patients are never fatigued, but from the first are very fond of it.

The co-operation of the family physician, as is mostly the case in this city, is always desired when practicable. Cases likely to be benefited are solicited through the profession.

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References:

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Original Lectures.

LECTURES ON DIPHTHERIA.

DELIVERED IN THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

BY

A. CLARK, M.D.,

PROFESSOR OF PATHOLOGY AND PRACTICE OF MEDICINE.

Lecture II. Part I.

Fibrous thickening of the lips of the glottis producing death, a case.—Death by convulsions.—An induced hemorrhagic diathesis usually mortal.—Paralytic affections following diphtheria.—Diphtheria postponed by scarlet fever and measles, a case.—Eruption of scarlet fever modified by concurrent diphtheria.—Intercurrent diphtheria not uncommon, usually occurring as the eruption begins to subside.—Concurrence of measles and diphtheria—Diphtheria and small-pox.—(Note—Diphtheritic ophthalmia.)

Gentlemen:—At the close of the hour when we last met, you will remember I was reciting some of the constitutional effects of the diphtheritic virus. It is my wish, as far as possible, to teach by examples; and as these constitutional effects are various, showing themselves as well after as during the membranous stage, I will give succinct narrations of still other cases; wishing you to regard each case as the type of a group, excepting only the first case which I give you to-day. That case will interest you, illustrating as it does, several important points in the natural history of our disease; but it would interest you still more if I were at liberty to refer to its social relations.

This larynx and portion of the trachea, with the tonsils, will show you a very marked thickening, particularly about the lips of the glottis. It is a thickening that resists the influence of alcohol, and therefore is not œdematous. I emphasize this point because, in the history of the case as I shall give it you directly, you might infer that œdema glottidis was the most natural condition to look for; but it is not so, it is a firm unyielding tissue at the upper part and opening of the larynx. A girl, two years old, not large for her age but usually healthy and vigorous, began to suffer with pretty high fever and sore throat. Membranous patches soon appeared on the tonsils, and the external glands of the neck were considerably swollen. On the fifth day of this disease a pretty bright efflorescence or scarlet fever eruption appeared, being first noticed in the morning, covering the whole body from head to foot; it lasted four days, and disappeared with obvious desquamation. The sore throat was not materially increased during the eruption, and the general symptoms were but moderately aggravated. The membranous disease continued through the eruption, and for two days after. Then the membrane exfoliated, and for two or three days more the throat and general symptoms gave promise of speedy recovery. But after this, one of the tonsils began to swell anew, and the glands of the neck on that side to increase and grow hard. In two or three days more, surgeons who were called in consultation thought they were authorized to open the external swelling to evacuate pus. It was opened, but very little pus was found. The difficulty of breathing, which had been gradually increasing for a day or two previous to this operation, soon became urgent. Search was made for a new deposit of false membrane in the fauces, but it could not be made out, though one of the surgeons thought he saw enough to authorize the opinion that it had been reproduced. The question of tracheotomy was raised by myself, and on consultation with three of the most distinguished surgeons of the city, it was declared inexpedient. The child died of apnœa; and a post-mortem showed that there was no reproduction of false membrane, but that the inflammatory non-œdematous thickening at the opening of the larynx had so narrowed the passage for the breath as to destroy by asphyxia. Tracheotomy in such a case might possibly have prolonged life till this tumefaction could have subsided, and the breathing could have been performed by the natural passages. But the case, so far as I know, is without a precedent in the history of diphtheria, and its nature could not have been understood previous to an autopsy.

The next case which I propose to recite may represent a small proportion of the fatal cases of diphtheria. Dr. Jas. R. Wood had several cases of scarlet fever in the family of one of my neighbors. In two of the cases there was diphtheritic disease complicating the fever. One of these did very well, except that the scarlet fever left deafness; another getting through the scarlet fever had the membranous disease in the throat; and that subsided, at least the membrane disappeared about the usual time. The little one was regarded as convalescent; still she was feeble, and kept her bed most of the day. Dr. Wood being out of town, I, having seen the child with him, was sent for one afternoon, and found that after a fortnight of apparent convalescence, she was seized suddenly about two o'clock that afternoon with convulsions. These convulsions continued to occur and recur until two the following morning, when the little one died. Here then is death by convulsions during what appears to be convalescence.

There is another source of danger, not exactly after the exudative period, but in its latter stages; it is *hemorrhage*. For example: Dr. Husted had a young man, his patient, seventeen years old, whose mouth, nose, and throat were the seat of diphtheritic exudation. Just about the time when portions of the membrane would have been likely to have exfoliated, there occurred a hemorrhage from the nose, mouth, fauces, and gums. This he succeeded in stopping by the use of the sesquisulphate of iron. Two days after this bleeding was renewed, the same agent would not control it nor indeed any other, and he died in a few hours. Dr. Buck's case, as published in the *American Medical Times* (Aug. 4, 1860), is an interesting one in this relation. He saw it at Paterson, N. J. A young man about fourteen years of age was attacked with diphtheria; the symptoms were not alarming from Wednesday until Saturday. On Sunday he had nose-bleed, and this was repeated several times. It does not appear that it was extreme and excessive, but it excited anxiety, and seemed to be an indication of the grave nature of the disease. This young man died not from the direct effects of the bleeding, but some *days* after, in a comatose condition. I cite these two cases to illustrate a principle which seems to have been settled ever since the time of the Spanish epidemics. For Villa Real, a Spanish author, writing of the Spanish epidemic which prevailed in the years preceding 1600, says: "I have very often observed that hemorrhage from the nose and mouth in this disease is fatal; indeed, I have seen no one survive in whom this hemorrhage from the nose or mouth has occurred." I do not know that we are compelled to take quite so gloomy a view of this feature of the disease, but certainly it is one of the gravest of symptoms.

Thus, then, you see, gentlemen, danger surrounds the little ones that are seized with this disease, on every side. It is not enough that there is imminent danger to the lives of these interesting ones during the continuance of the exudation; but after the membrane has separated, the poison sometimes still continues to work on the system, and produce effects which, as I said before, last for months, and occasionally for a year or two. We have not done with the characteristics of diphtheria, for there are sequences even later than those I have yet referred to. These, however, are in great part paralysis in some form or another. You will, perhaps, remember, some of you, to have seen in this room, during the last summer, a child about six or eight years old, that was brought here for a diagnosis. She had had diphtheria, and four weeks had elapsed since all danger from that disease was supposed to have passed. When she was here, there was manifest a certain degree of stupidity in her manner; one of the eyes was turned inwards towards

the nose; there was a very marked weakness of the whole of one side. The symptoms led me to suspect the existence of acute hydrocephalus. But in a little time it appeared that there was no danger from hydrocephalus, but that this was a paralytic affection, which was the result of the diphtheritic poison. In two or three months of tonic treatment this paralysis all disappeared; the sight became straight, recovering its usual force. This strabismus was in all probability the consequence of paralysis of the external rectus, the other muscles retaining their force would displace the eye from its proper axis.

Paralysis of the fauces is a common occurrence following after this disease, lasting for two or three months, and causing a considerable alteration in the tone of the voice, and difficulty in swallowing. This alteration in the voice is the consequence of one of two things—either a swelling of the tonsils, which remains after the membranous affection has ceased, or of a paralysis of the muscles of the throat, which may either remain over or occur after the active symptoms have gone. The paralysis of the velum is usually attended by insensibility in the part, so that it may be pinched or pricked without producing pain. Regurgitation of the food through the nose with cough is a common occurrence with this paralysis. It occurs oftenest in the attempt to swallow fluids. It was noticed by Dr. Samuel Bard (*Am. Philos. Trans.*, vol. i. p. 388).

Again, *paralysis* in a variety of ways shows itself in different parts of the body. As an illustration of this, the *eye* is sometimes affected in other ways than by the production of strabismus. A patient of Dr. Henschell, a boy who had had diphtheria, was so far recovered as to be actually sent away to school. As he attempted to study, it was ascertained that he could not see. The teacher, taking the alarm from this circumstance (the boy at the same time looking pale and feeble), sent him home again. When he came to be examined carefully, it was ascertained that he could see distant objects tolerably well; but it was the things in the room that he could not distinguish satisfactorily; as to print, there was none so large that he could read. The question arose, Is this an amaurosis, or is it the result of paralysis in the muscular apparatus that adjusts the eye to distances? I call your attention particularly to this point, for you will see, when you read Greenhow's book, that there is a doubt on his mind whether this affection is a true amaurosis or muscular paralysis. There was but one way to decide this point. We obtained some spectacles of varying focal distances, and found that those of moderate convexity enabled him to see considerably better; but the very oldest glasses were those by which he could see and read the very finest print. It was plain from this circumstance that the eye was sound, and that it had not the power to adjust itself to nearer objects. Another case of the same sort occurred a short time afterwards. It was tested in the same way; there was no amaurosis. In this the paralysis of the muscles did not come on until the fifth and sixth weeks of the convalescence. In both instances entire relief was obtained in one or two months by the use of tonic medicines. Actual but temporary amaurosis is said to have occurred under similar circumstances. Eyes so affected have been examined by the ophthalmoscope, and nothing unnatural has been discovered. I have no difficulty in admitting the possibility of such a lesion; but I cannot yet learn that any of our ophthalmic surgeons have seen it here; and as our cases of supposed amaurosis have been resolved into muscular paralysis, it is right to submit the question to further investigation.

Dr. Herpin's case is a curious instance of paralysis affecting large portions of the body. A fortnight after incomplete recovery he had "pain in the wrists; confusion of sight; constriction of the throat; paralysis of the palatine vault, which had become completely insensible; regurgitation of food by the nostrils. Rather later, there was a sensation of tingling in the great toe, ascending as high as the knees. I walked," he says, "with great difficulty, and very slowly, and my weakness was especially painful when I went up stairs, and this state continued without improvement for six weeks. The same tingling had reached my hands and fingers, and I had complete loss of all tactile power." He took the disease in the spring of 1843. "On the 10th of August I took sea baths, and at the second bath I was entirely cured of all my complaints." In one of Bretonneau's patients, such insensibility of the lower extremities occurred while the muscular force remained; that though he felt well, and could walk, he had to look to the ground to ascertain that his feet were securely planted. He felt as if he was walking in the air. Salt-water baths, as salt as sea water, appeared to be beneficial. This state existed three months after convalescence. (Memoirs, p. 203.) Trousseau has reported a case of exceeding interest, in one view:—The paralysis that affected the muscles of the legs and arms seemed to be complete at times, and then it would change from one side to the other in a single day, and go back again. The importance of this fact is to be seen in the inference that must be drawn from it, that the paralysis does not depend upon any permanent change in the nerve tissue anywhere, either in the nervous centres or in the nerves themselves; that it is a functional disease the nature of which is not understood. In almost all these instances of paralysis, after one to three months, recovery takes place pretty rapidly, under the influence of fresh air, sea bathing, or salt-water bathing, and tonic medicines. These cases will serve, then, to illustrate the various modes in which this formidable disease affects the system, before, and at the time of the occurrence of the membrane, and for months afterwards. You may regard Dr. Herpin's as a type-case, not in the time at which the paralysis occurred, but in the order in which it attacked the different parts of the body. As a rule, you may expect paralysis and insensibility of the hanging palate first, with nasal voice, and in some, regurgitation of fluids by the nostrils; then, some time after, tingling in the toes, feet, and legs, followed by motor and sensory paralysis, one or both, more or less complete. Then, still later, the tingling in the hands, followed by loss of the tactile sense, or of motor power, or both. Generally it has proceeded no further; but instances are recorded in which it was believed that the respiratory muscles had become paralysed, and even the heart. However this may be, it is pleasant to know that almost all of these paralytic sequelæ are remediable, whether of sensation alone, as in Bretonneau's case; or of the muscles of the throat; or of those of the eye; paraplegia or hemiplegia; of whatever part, for it is difficult to say what portion of the body is exempt from this infirmity. Almost all the cases that have not had a favorable issue have been made fatal by the force of some intercurrent disease. There is no common mode of death, as in affections naturally fatal, except in the rare and doubtful cases in which it has been supposed that paralysis had seized on the heart or the respiratory muscles. You may be led to infer from these remarks, that the paralytic affections are to be looked for in a large proportion of the cases of diphtheria. The muscular paralysis of the fauces with or without loss of sensation in the hanging palate, is, as has been said, a common occurrence. But in other parts of the body I do not think you will find it oftener than in one out of twenty cases, or more, of the membranous affection. I cannot tell you how often, in those who suffer in this way, you should look for loss of sensibility alone; or for muscular paralysis alone; or for the two combined; nor how often the paralysis will be paraplegia; or hemiplegia; or only affect single muscles, as the external rectus of the eye (producing strabismus); or sets of muscles belonging to one part, as when an arm is alone paralysed, or the vision is impaired. But in an extensive epidemic of diphtheria you may expect to see, from time to time, all these, and occasionally general paralysis. This subject has been well written up by our townsman, Dr. James B. Reynolds. You may find his interesting paper in the *New York Journal of Medicine*, May, 1860, p. 316. I have dwelt upon it longer

than its relative importance demands, but it interests me greatly, as the strangest of all the phenomena of this singular disease, and because the study of it throws some light on other forms of paralysis.

The relations of scarlet fever and diphtheria are interesting. Many persons have said that they were one and the same disease; I shall, by and by, give you reasons for inferring that they are not. My present purpose is to show some curious modifications of each of these diseases produced by the other. A patient of Dr. Harris had, on the 10th of January of last year, diphtheritic inflammation of the throat. It continued for two or three days, when febrile symptoms of a more active character occurred, and pretty soon there was evidence that scarlet fever was about to make its appearance. The eruption came out, ran its course, the membrane disappeared; the throat, however, remained swollen and red, as it commonly is in scarlet fever, and the external glands of the neck also remained much swollen. On the subsidence of the scarlet fever the eruption of measles followed; this ran its usual course, and subsided without reproduction of the membrane. In about twenty-one days from the time of the first occurrence of the diphtheria—that is to say, on about the last day of January—the eruptive diseases having subsided, diphtheria reappeared, the swellings in the neck increased, the membrane penetrated into the trachea, and in two days this little child died. Now, an interesting question occurs—Why should this diphtheritic disease appear, then give place to other affections, still retaining its hold upon the system, to reappear after an absence of eighteen days? All we can say is, that in this particular instance there was a certain degree of antagonism between those eruptive diseases and the membranous diseases, in consequence of which the latter was compelled to wait for the former.

In another instance scarlet fever occurring in a boy, one of six children, suffering from that disease, at the same time, in a family attended by Dr. J. J. Crane, of this city, and Drs. Crane and Green, of Elizabeth, N. J., concurrent diphtheria produced a singular modification of the exanthem. One of his sisters exhibited the same peculiarity. When I saw these cases, three of them had diphtheria; the eruption in one had existed for eight days, and was as bright as it usually is on the third day; in her, membranous disease of the throat, of the tonsils, nasal passages, and larynx, existed at the same time. She recovered. In the boy, the eruption had existed for eleven days; it was still bright, and desquamation was active over the red eruption. It lasted till he died, four days afterwards. It seemed to have been caught and imprisoned there. In him the diphtheritic inflammation affected chiefly the fauces and the nostrils.

In the instance I just now cited of inflammatory swelling of the glottis, it was four days before the eruption of scarlet fever made its appearance. The eruption, instead of lasting six days, disappeared in less than four days; instead of beginning in the upper part of the body, extending gradually over the surface, it came out upon the whole body at once. It must have been somewhat modified by the previous existence of the diphtheria. In general, where these two diseases concur, the scarlet fever advances to about the period where the eruption begins to disappear upon the upper part of the body, the throat still remaining inflamed. This is the favorite time for the occurrence of membranous disease in the fauces. The membrane once formed, the disease follows the ordinary laws of diphtheria affecting the same tissues, but is attended, as I should judge, by a much greater mortality.

This same complication may be met with in measles. We have not seen much of it in New York, though it is spoken of in the occurrence of the disease abroad. Mr. Ryland, reporting from Birmingham, records an epidemic, occurring in 1856, in which diphtheria and measles were found to concur. In one case, that of a delicate child, aged five years, the eruption of measles was reported to have occurred on the 8th of June, 1856. Two days after, the measles still continued out, the bowels were relaxed; the breathing was accelerated, and attended with mucous rattle; there was great difficulty of swallowing; a hoarse cough and almost total suppression of the voice; the back of the fauces could not be seen, but there were spots of membranous concretion on the roof of the mouth. The case proved fatal. On post-mortem examination, a thin, ash-colored membrane was found covering the uvula, a portion of the pharynx, the laryngeal surface of the epiglottis, and the lips of the glottis as far as the ventricles of the larynx. "About the same time many children died of a similar affection of the throat, complicated with measles. They had, in most instances, cough, difficulty of swallowing, impeded respiration, hoarseness; ultimately, suppression of the voice; and, in many cases, swelling of the submaxillary glands." Guersant and Daviot both recognise a disposition in the pellicular exudation to occur in the course of epidemic measles, scarlatina, and small-pox, and that it is in such cases that true gangrene is most likely to be met with in conjunction with diphtheria, showing itself with or after the exfoliation of the false membrane.

Diphtheria is reported to have occurred in persons suffering from various other diseases, for example, from abscess, pneumonia, gonorrhœa, etc. But its occurrence in such cases, according to the present state of our knowledge, must be looked upon as accidental. It seems to have a more natural affinity to such affections as produce inflammatory excitement in the throat and air-passages.

NOTE.—*Diphtheritic Ophthalmia.*—Dr. Noyes has been so kind as to bring to me a case of ophthalmic diphtheria for examination, since the second part of my first lecture has been in type; and at my request he has been good enough to give me a synopsis of some observations made in Germany on that affection, and also a report of the case here referred to. To-day (March 30) he brought me portions of the membrane taken from the eyelid. We examined it under the microscope, and found that it was composed of the elements which usually constitute the membrane of diphtheria when it appears on other surfaces. A fine fibrillation is the basis of this exudation, and the fibres are everywhere sprinkled over with minute granular matter. But there are parts in which no fibres can be seen. In such parts the small nucleated and the elongated cells take their place. Pus cells are also seen overlying the fibres in certain parts. These were probably produced on the attached surface, though possibly on the free, as this exudation is the growth of twenty-four hours, and a second membrane from the same eyelid.

I offer the following contribution of Dr. Noyes for publication because, in giving the results of an extended observation, it softens the too stern inferences that we should be compelled to draw from the Randall's Island cases alone, those being nearly all of them diphtheria engrafted on measles; and because it shows us a wider range of circumstances under which the ophthalmic disease may occur.

MARCH 30, 1861.

The most complete account of this diphtheritic conjunctivitis is by Prof. Graefe, published in 1854, Archiv für Ophthalmologie, Bd. 1, Abth. 1. The article is now being translated, and appears in the London Medical Review. He observed three epidemics from 1852 to 1854. In each epidemic the earliest cases were the most severe. He thinks the disease decidedly contagious. As to the danger of the disease, it consists in the communication of inflammation to the cornea. Of forty children, in nine cases the eyes were totally lost, three had leucoma with anterior synochia, in seven there were left corneal opacities, and twenty-one recovered with unimpaired sight. Of eight adults, three lost sight by suppuration of the cornea, in two the cornea was perforated by ulceration, and the remaining three had opacities. The danger to vision is greatest the earlier the cornea becomes affected, and as seen above adults suffer more severely than children. During the time that the exudation persists he treats the disease by the use of mercurials and tonics, by leeching if the strength be good, and

by ice-water lotions; when the exudation falls off and the blennorrhœal stage is set up, he employs nitrate of silver, as his practice is in cases of simple purulent conjunctivitis. Sometimes the disease leaves a distortion of the eyelids from contraction of the conjunctiva.

There is another account of this malady by Dr. Jacobson, Archiv für Ophthalmologie, Bd. 6, Abth. 2, 1860. He saw twenty-two cases in epidemics of diphtheria, and forty sporadic cases, among two thousand patients during five years. The summary of results is—out of seventeen patients, there being twenty-two eyes affected. Five eyes utterly destroyed, four had adherent leucomata, six retained corneal opacities, four escaped without injury, and in three the diphtheritic inflammation effected the removal of pre-existing pannus of the cornea. The treatment was the constant application of iced water, scarifications of the conjunctiva of the lids. If the cornea began to be affected, dropping a solution of atropine, gr. ij. ad aquam ʒj, frequently into the eye; if perforation of the cornea was threatened, to evacuate aqueous humor, and do it repeatedly if supra-orbital pain or increase of the ulcer indicated its necessity. Nitrate of silver and mercurials were discarded as injurious.

The forty sporadic cases terminated in a much happier manner—no eyes were destroyed or suffered serious damage.

A case is reported by Mr. Hutchinson in the Ophthalmic Hospital Reports, October, 1859, page 130. He scraped off the membrane, and cauterized the surface with nitrate of silver. The cornea sloughed, and subsequently, from the debilitated state of the child, an abscess formed over the shoulder.

The following case is the first of diphtheritic conjunctivitis which has presented itself at the New York Eye Infirmary during the last eighteen months, viz.:

Joseph B——, aged 2½ years; a pale, delicate child, who has had measles, varioloid, dysentery, but for a few months been in better health than usual. Ten days before coming under observation, the right eye became inflamed; at the same time the child became very fretful, had cutaneous eruptions of small white and red spots, not vesicular. At present, is very unwilling to be examined in any way; pulse 128, weak, has no diarrhœa, sleeps badly, the tonsils swollen, no exudation in fauces. The eyelids are very tumid, and of a dusky red color; a muco-purulent secretion flows over the cheek. On everting the lower lid, a yellowish matter covers its surface, excepting at the cul de sac, where the membrane presents a deep red color. This yellowish matter adheres closely where the attempt is made to wipe it off, only particles are rubbed away and the surface begins to bleed. The exudation has formed in spots upon the cutaneous surface as well as upon the margin of the lid. The conjunctiva bulbi has a pale look as if infiltrated with lymph, although not overlaid like the palpebral conjunctiva. There is no chemosis. The disease having lasted ten days, the exudation is beginning to separate at the edges, and exposes an intensely congested, sacculent mucous membrane, like an ordinary case of purulent conjunctivitis. The cornea has preserved its transparency.

The termination of the case will be hereafter reported. I could not learn that diphtheria, or any infectious disease, existed in the tenement house where this child lived.

H. D. Noyes.

CLINICAL LECTURES.

DELIVERED IN THE N. O. CHARITY HOSPITAL.

By AUSTIN FLINT, M.D.,

PROF. OF CLINICAL MEDICINE AND MEDICAL PATHOLOGY, IN THE N. O. SCHOOL OF MEDICINE.

Lecture VI.—Pneumonia.

PHYSICAL EXAMINATION OF PULMONARY CAVITIES.

I shall to-day invite your attention to an important subject. I have before me the lungs from the body of a patient who recently died in one of my wards with pulmonary tuberculosis. The patient was in the ward when my service commenced, October 25. He had been in the hospital since May last. I found him extremely feeble, and he continued to decline steadily and died a few days ago. I shall not detain you with a history of the case. I will only remark that it furnished an illustration of the remarkable serenity of mind and hopefulness which we frequently observe in the progress of this disease. The patient made no complaints, daily reporting himself more comfortable. The emaciation, anæmia, and feebleness were painfully in contrast with his belief in his progressive improvement and steady conviction that he was on the road to recovery. He died apparently without having had any apprehension that his disease was likely to end fatally. This state of mind in the present instance amounted to an insane delusion with respect to recovery.

The lungs, as you see, at their apices are invested with firm false membranes. The opposed pleural surfaces were strongly united in these situations, while the remaining portions of the organs were free from adhesion. The pleuritic attachments which are almost constantly found over tuberculous deposits in the lungs, are conservative provisions protecting against an accident which occasionally occurs, viz. perforation of the lung, and the escape of liquified tubercle into the pleural sac. Under these circumstances acute pleuritis becomes developed, and air gets access into the pleura, so that we have the affection known as pneumo-hydrothorax, an affection which generally destroys life in a short time.

I wish especially to direct your attention to the upper portion of the left lung in this specimen. On cutting into this lung at its apex, I have opened a cavity of considerable size. It is larger than an English walnut, and nearly as large as a small orange. The cavity is empty. Its internal aspect presents several furrows caused by projecting ridges of condensed pulmonary substance. This appearance is called anfractuous, and is characteristic of tuberculous cavities. A band of condensed pulmonary tissue traverses a part of the cavity. This is often seen in tuberculous cavities, and explains the occurrence of hæmoptysis in some cases of advanced phthisis. These bands may contain bloodvessels, and, when ruptured, the vessels are opened, and hæmorrhage takes place, which is sometimes profuse. I wish you to observe that the walls of this cavity, at its upper and anterior surfaces, are quite thin, consisting only of the pleura with its false membranes and a layer of condensed pulmonary tissue not more than a line or two in thickness. I wish you also to observe that the lung surrounding the cavity is not solid but soft, and to some extent crepitating. On cutting into it a puruloid liquid flows from the divided surfaces, and numerous minute cavities from the size of a pin's head to a pea are seen, but no deposit of crude tubercle.

Now let me direct your attention to another point. I introduce the nozzle of a pair of bellows into the left bronchus, and close the incisions which I have made into the lung below the cavity. You see that air enters very freely into the cavity through five or six openings, the situations of which are shown by air bubbles. The cavity, then, had free communication with the bronchial tubes through these several openings.

I shall now cut off the upper portion of the left lung, and send it round for your closer inspection.

I have pointed out the situation of this cavity and other circumstances for a particular purpose. This will appear as I proceed to read a part of the record of the physical examination of the chest in this case, noted in my book of hospital records three weeks before the death of the patient. I read as follows:

"At the summit of the chest on the left side in front and behind there is relative dulness on percussion. Over a circumscribed space below the clavicle the respiration is cavernous; the inspiratory sound is non-vesicular and low in pitch, and the expiratory sound is still lower in pitch.

This circumscribed space is of about the size of a dollar. Below and around this circumscribed space the respiration is bronchio-vesicular, or what has been commonly called rude, that is, the inspiratory sound is partly vesicular and partly tubular, and the expiratory sound is higher in pitch than the inspiratory. Within the circumscribed space just mentioned the cavernous whisper is heard, i. e. a blowing sound low in pitch; around this space the whispering sound is bronchial or high in pitch. The vocal resonance is greater on the left than on the right side, but there is no approach to pectoriloquy anywhere."

Thus, gentlemen, it appears that the cavity which you are now examining was localized during the life of the patient by certain physical signs explicitly recorded, and the size as well as the situation of the cavity was noted. Now, it is not my purpose to convince you that, after having devoted considerable attention for not a few years to the subject, I have acquired some skill in physical exploration. There was in reality no great amount of skill involved in the localization of the cavity in this instance. There are those in the class before me who would have had no difficulty in discovering the cavity. I have another purpose, which is to make a few remarks on certain cavernous signs which I claim to have ascertained, and without which I believe cavities cannot be correctly localized.

Without going fully into the history of the subject here, I will firstly say that, anxious as was Laennec to determine a series of signs peculiar to cavities, he succeeded but imperfectly. The cavernous respiration as described by him, has been abundantly disproved, and pectoriloquy has been shown, not only to be very often wanting when cavities exist, but to be present when cavities are wanting. Later observers in this field of study have not succeeded better. By some, bronchial respiration has been considered as cavernous under certain circumstances, and Walshe states that cavernous breathing sometimes occurs over solidified lung when no cavities exist. It appears to be a common impression among many who practise auscultation, that an intense bronchial respiration denotes a cavity, and as this impression is altogether incorrect, errors are often made.

In an essay on the variations of pitch in percussion and respiratory sounds, published in 1852,* I suggested as probable the distinctive characters of cavernous respiration as described in the record of this case, viz. a low-pitched non-vesicular inspiratory sound, with an expiratory sound still lower in pitch. These characters are in contrast with those which belong to the bronchial respiration, the latter consisting of a high-pitched tubular inspiration and an expiratory sound still higher in pitch. In the essay referred to, these characters of the cavernous respiration were given with a reserve, which was considered as proper, inasmuch as their correctness had been verified in only a few cases. In my work on the respiratory system, published in 1856, I gave the same description of cavernous respiration, but I stated that the respirations at that time had not been numerous. They have been, to my mind, sufficiently numerous since; and for the last two or three years I have never failed to demonstrate to classes of private pupils in auscultation the cavernous respiration as distinct from the bronchial.

I do not complain that others have not adopted my description of cavernous respiration, and that writers, even in our own country, make no allusion to it; for, if the description be correct, it will sooner or later be so recognised. All that I claim for it is that it be submitted to the test of clinical observation by competent observers in this department of study. With the hope of securing this end, I am glad to avail myself of proper occasions to bring it to the notice of auscultators.

Another cavernous sign which was frequent in this case, is, so far as I know, original with me. I refer to what I have called the cavernous whisper. After the publication of the essay just referred to, I was interested in the study of sounds produced by the whispered voice. Over solidified lung, when the patient speaks in a whisper, a high-pitched souffle, or tubular sound, is usually heard. This sign is correlative to the bronchial or tubular respiration. In the winter of 1855 I was led to observe that over a pulmonary cavity the souffle produced by whispered words is low in pitch as compared with the high-pitched sound, denoting solidification of lung. The latter I have named whispering bronchophony, or the bronchial whisper, the latter term being preferable as the simpler and more expressive of the two. The term tubular whisper would also be appropriate. The sound heard over a cavity may be distinguished as the cavernous whisper. I have noticed this sign in an appendix to my work on the Respiratory System. The cavernous whisper is correlative to cavernous respiration, for the same reason that the bronchial or tubular whisper is correlative to the bronchial respiration. The whispered sound is, in fact, only the expiratory sound more intense than in ordinary breathing. If, therefore, bronchial respiration be characterized by a high-pitched expiration and cavernous expiration by a low-pitched expiration, we can readily understand that the same difference should hold good between a bronchial and a cavernous whisper as regards pitch. Clinical observation shows this to be true.

Dr. Walshe, in the late edition of his able work on the diseases of the chest, does me the honor to notice my account of cavernous respiration in the following terms: "It has been suggested by Dr. Flint that bronchial respiration may be always distinguished from cavernous by the relative pitch of inspiration and expiration—the latter higher than the former in bronchial, lower in cavernous breathing. Exceptions are so common, I fear, as to render this alleged rule unworthy of trust." I can readily understand how Dr. Walshe arrived at this conclusion, assuming that he has not made the subject one of deliberate clinical study. If the true cavernous respiration be such as I have described when it is distinctly present, it always denotes a cavity. It can signify nothing else, as well marked bronchial respiration always denotes solidified lung. There are no exceptions to the rule. But the cavernous respiration is by no means always present where centres, even of considerable size, exist. The absence of cavernous respiration is not evidence against the existence of a cavity, but its presence is proof that there is a cavity. The truth is, we get bronchial respiration oftener than the cavernous, even directly over a cavity. The explanation of this is obvious. Cavities are often surrounded with solidified lung, and the bronchial respiration, representing the latter, drowns the cavernous respiration. Then, the latter requires for its production that the cavity should be empty, that it should communicate freely with the bronchial tubes, and that its walls should collapse and expand with the acts of expiration and inspiration. For the cavernous respiration to be produced, in addition to the conditions just mentioned, the cavity must be superficially situated, and not surrounded with complete solidification of lung. A cavity situated within a mass of solid tubercle or condensed pulmonary tissue, will not be likely to furnish the cavernous respiration unless the cavity be quite large, or unless, for some reason, the solidified lung fail to give an intense bronchial respiration.

In the specimen, gentlemen, which you are now examining, all the necessary conditions for the production of the cavernous respiration and the cavernous whisper are present. The cavity is large; its walls are thin, and readily collapse; it is superficially situated; it communicates freely by several openings with the bronchial tubes, and the lung surrounding it is not solidified sufficiently to produce the bronchial respiration. These circumstances account for the fact that the cavernous signs were so extremely well marked.

In leaving this subject, I would remark, that not unfrequently we find the characters of the cavernous and the bronchial respiration combined in variable proportions. Appreciating the distinctive characters of each, it is, I think, easy to recognise the fact that they are combined in certain

* Trans. Am. Med. Association, Vol. ii.

cases. We can understand readily why this should be so, when we consider, as just stated, that cavities are so often surrounded, more or less, with solidified lung. I have repeatedly observed an inspiratory sound to commence as bronchial and end in the cavernous—that is, the sound suddenly falls from a high to a low pitch during the inspiratory act. The reason of this is, the bronchial inspiratory sound is more quickly evolved than the cavernous. To express the combination of bronchial and cavernous characters, I have employed the term bronchio-cavernous respiration, which, as it is purely a descriptive term, does not complicate the subject, and is often a convenient mode of expression in recording cases.

Original Communications.

RELIEF OF CERTAIN FORMS OF APHONIA BY ANÆSTHETIC VAPORS.

By FREDERICK D. LENTE, M.D.,
OF COLD SPRING, N. Y.

The recent occurrence of a case of this kind, of which the following is a brief abstract, induces me to give publicity to one very similar to it, which occurred in my practice a few months ago.

T. B., æt. 19, a carman, living in London, was attacked in the early part of 1860, with hoarseness, enlargement of the sub-maxillary glands, and sore-throat. In March, he applied at one of the Dispensaries for relief, and was treated, but without much benefit; he then applied in turn, at several other hospitals, including St. Bartholomew's; having, in the mean time, entirely lost his voice.

In December, he applied to the district medical officer, who, on examining the throat, found the left tonsil slightly inflamed, but no other appearance of disease, and could detect no syphilitic taint or history. He, however, noticed considerable rigidity of the muscles of the jaw, and thought it advisable to try the inhalation of *chloroform*. "He was accordingly placed under its influence, and its effect was truly magical, as he called out for his mother quite distinctly. He went home, and agreeably surprised his friends by speaking to them the first time in *eight months*, articulating every syllable." A week afterwards, his voice had not left him.

The following is a brief history of my own case. Miss M. W., an unmarried female, about 40 years of age, has been for the most part bed-ridden for the last ten or twelve years, apparently from the effects of a violent and protracted attack of dysentery, for which she was treated by another physician. During all this time, she has also been more or less troubled with a reducible femoral hernia. She has never been at all hysterical, or even nervous, in the usual acceptation of the term. Some time in the early part of 1860, she lost her voice, so that she could not articulate above a whisper. This was a source of great annoyance to her, as she is very fond of conversation. She was, of course, very solicitous to have something done for her relief; but, as I could discern no lesion whatever about the fauces or larynx, and could assign no possible cause for the *aphonia*, I was at a loss what course of treatment to pursue, and so did nothing, comforting her with the hope that she might one day regain her voice as suddenly as she had lost it.

In December, 1860, her hernia came down, could not be reduced, and became strangulated, resisting all the attempts of Dr. Richerson, who was first called, and of myself subsequently, to reduce it. In our attempts, we used the inhalation of sulphuric ether twice each time, the patient, on her recovery, expressing her belief that she articulated with less effort, although she still spoke in whispers. Finally, a resort to the knife became necessary, and she was again brought fully under the influence of the anæsthetic. The operation was protracted from several causes, and she was under the full influence of the ether for nearly two hours. As soon as she had fully recovered from the effects of the anæsthetics, she exclaimed, apparently with the greatest delight, and in quite an audible voice,—"Doctor, I can speak," and she has been "speaking" fluently ever since, now nearly three months.

I always had a suspicion that *hysteria* was at the bottom of this case of aphonia; and Dr. Richards, the reporter of the London case, asks—"May it not be reasonable to conclude that this case was one of mere hysteria?"

It is possible that many chronic forms of throat difficulty, whether attended or not by aphonia, might be benefited, when all other means fail, as they are so apt to do, by the stimulating, anæsthetic, or antispasmodic effects of ether or chloroform, which treatment, the perusal of these cases may induce others to try.

VERATRUM VIRIDE IN PNEUMONIA.

By SAMUEL PETERS, M.D.
Crescent, Saratoga Co., N. Y.

It is well understood in the profession, that a few of its members repose great confidence in the use of veratrum viride in pneumonia. I wish to record my humble name among this few. Having been for several years a careful observer of its powers in this disease, I deem it due to the profession that I make known the result. This is done with the greatest pleasure, from not having met with that accumulation of favorable testimony in the journals, which I expected. Moreover, Prof. Wood says, in his Therapeutics, vol. ii., page 155 (and no one will dare to question such authority hastily), that "it should not be employed to the exclusion of the lancet;" also that "when the state of the system does not admit of depletion, it may sometimes, I have no doubt, be employed with advantage;" and again that, "it has been much employed, especially in the South, where pneumonia often assumes a form which does not well bear depletion."

Now, as my observations have led me to a conclusion somewhat differing from what is taught in the above quotations, the propriety of this simple statement will be admitted. I shall not attempt a discussion of the question of depletion, which has been fairly met by some of the distinguished leaders in the profession, and ably and fearlessly discussed. I will only here endorse the language of Prof. Flint: that "I do believe, that in the great majority of cases, even when the disease is observed from its commencement, blood-letting is not called for."

My first experience in the use of veratrum occurred in April, 1855. I selected a case the subject of which was a man about twenty-eight years old, of spare form and thin chest, whose mother had previously died of Phthisis. His right lung was extensively inflamed, and I believe that under the ordinary treatment he would not have survived. He made a perfect recovery, not, however, without encountering great danger. Soon after this, it was made use of in other cases, and since that time I have scarcely passed a day without having it in my possession. The number of cases I have treated with it, cannot be given. It is, however, not small, and although I have *depended* on it in every one, except infants of a few months, not one has proved fatal. This success may, perhaps, be partially attributed to the fact that there have happened in connexion with the cases, no serious complications. Children and adults of various ages, from two to eighty years, and of almost every grade of constitution, have been subjected to its action, and the result has been perfect recovery, so far as I am aware, in every instance.

Although I will not assume the responsibility to condemn remedies, nor would I wish even to weaken unduly any confidence reposed in them, yet in a general practice in pneumonia, I have not employed venesection, antimony

and calomel (except in one case, which will be shortly noticed), because they did not seem to be called for by any peculiarity which would imperatively demand their use; and moreover the convalescence after the veratrum treatment appeared to be more rapid and favorable. The case excepted, was one of extreme congestion of nearly the entire both lungs, in the person of a full-chested, thick-necked, muscular man, about thirty-eight years of age, in whom suffocation strongly threatened. In such a case, venesection boldly carried out, offers, I think, the only chance for aiding this vital organ in carrying on a degree of aëration of blood sufficient to sustain life, till the action of other appropriate remedies can be secured. In the language of Dr. Markham, London Lancet, 1858, vol. i., page 206, "it is practised here, not so much to reduce the inflammatory process, as to set free the action of a vital organ." With such exceptions, the early stage, the bounding pulse, the painful respiration, and the young strong subject, will not, as they have not done hitherto, tempt me to resort to the lancet. Laxatives, opium at night, demulcents, occasionally a blister and animal broths after the veratrum has established its full influence on the circulation, comprehend about the only agencies employed.

The usual duration of the disease from its commencement of treatment, to the establishment of convalescence, was six or seven days. In a few cases, this period was much shortened, convalescence being fairly established in two or three days. In this, I cannot be mistaken, as they presented the usual subjective and physical symptoms.

The plan of Dr. Norwood was to commence with seven or eight drops, and repeat every three hours, increasing one drop at each dose, till emesis occurred, or the pulse was diminished in frequency, then to reduce the last dose one half. This course I found produced powerful action, and generally caused such a degree of alarm, that the attending physician was hastily summoned, even after an explanation had been previously given of the harmlessness of the symptom; when the appropriate remedies were resorted to. This great obstacle to its general use was obviated by smaller doses in the commencement, and a more gradual increase. The better way is to order about four drops every three hours, and increase one drop every fourth dose, till vomiting ensues, or the pulse becomes reduced in frequency or free perspiration is induced; in either case, to diminish the dose slightly. Administered in this way, I have never observed any of its alarming effects, although I have persevered with it for days together uninterruptedly.

Compared with digitalis, in reference to its convenience in meeting the demands of the country physician, for agents that can be managed by ordinary attendants, veratrum, as a nervous sedative, is far superior, both in respect to its safety and to the certainty of its action. I believe, however, that it possesses little value, unless its controlling action upon the circulation be secured and steadily maintained; and that this maintenance can only be effected by the frequent repetition of the dose. In this respect, it is entirely unlike digitalis, which generally continues in action for several days. In old persons, with enfeebled constitutions, I have been particularly gratified with its favorable action. To observe it softening and cooling the surface, bathing it in free perspiration, removing gradually the anxious expression of countenance, promoting free and easy expectoration, and all with a certainty of action that can be realized of few other remedies, is surely enough to demand the confidence of every observer.

APPEARANCE OF A BODY

AFTER FIVE AND A HALF MONTHS' INTERMENT.

By W. H. BUTLER, M.D.,

EAST SAGINAW, MICH.

I copy from my note-book the following case occurring in practice in Buffalo, thinking it may be of interest or importance in a medico-legal point of view.

March 30th, 1859, made a post-mortem on the body of W. M. Drs. Rochester and Barnes present. The man had been a hard drinker for several years. Two days before death he was taken with delirium tremens, and a physician saw him but once. Some suspicious circumstances coming to the knowledge of the authorities, the case was referred to Coroner Randall, who ordered the exhumation of the body. The subject was about forty years old—was buried October 15th.

General appearance of the body a greenish black color; much decomposed; wasted; discolored, and having a very offensive smell; cuticle softened, desquamating, and gone in some places; teeth eroded. Eyes sunken, not decomposed; their color cannot be distinguished, probably owing to absorption, wasting of the iris, or ulceration of the cornea, which takes place so often in the dying and dead, giving a glazed appearance to the eye. Omentum of considerable thickness, and I thought approaching adipocire, of a cream color, and pretty firmly attached at its upper edge. Pericardium of a pale pink color, very dry. The heart seemed like brown paper, dry and crumpled; the cavities and columnæ carneæ had apparently all wasted equally; the walls were about the thickness of brown paper, say one-twentieth of an inch. The interior presented a beautiful tracing of the fleshy columns—quite delicate, but perfect. There was no fluid in any of the blood-vessels. Lungs collapsed and disintegrated. Liver presented a very intense blue or bluish-green color, doughy to the fingers, the impression remaining and feeling like putty, cut dry. It seemed to me large proportionally, extending as it did well over against the left ribs. Gall-bladder empty. Stomach reddish-brown color, had a small contracted appearance, which on cutting open was shown to be due to a folding over on itself. Internally it had a highly injected appearance with spots of gangrene at the greater curvature near œsophagus, and also where it had been folded together, particularly the lower part. Mucous surface dry, and of the appearance of thick brown paint. The lower part doubled over on itself, and there it was greenish blue or gangrenous; cut pretty firm. Noticed quite large blubbers or blebs filled with gas between the coats of the stomach. The lower part of the ileum highly injected and red for a considerable space from junction with colon upwards; and towards its middle, other spots. They were somewhat contracted; generally pale in color with injected spots; pretty well preserved. Some of the intestines near the liver stained with bile; kidneys normal in size, dark color and softened: the centres of a slate color. I found little brownish granular bodies over nearly all the viscera; they were quite firm, and not easily scraped off by the scalpel. These were seen particularly over the lower edge of the liver, on the heart, in the arteries near it, and in the arteries of the kidneys.* I learned that the body was buried four and a half feet deep, and noticed on the coffin yellowish loam, and subsequently learned the ground was of a dry yellow earth. This may in some manner explain the apparently dry rot (if I may be allowed the expression) that seemed to have acted on the body, taken in connexion with the cool weather at the time of interment.

It had been charged that the subject died of poison, as vomiting, purging, and other symptoms pointing that way had occurred just before death: but on the inquest a respectable physician testified to the unmistakable symptoms of delirium tremens being present two days before he died, and several persons corroborated the testimony. It also appeared that he had for many years been a hard-drinking man. These facts, with the absence of any well grounded reason for the commission of so grave an offence, rendered the analysis of the viscera unnecessary. It seemed as if the only physical signs worthy of attention were the preservation of the body; gangrenous spots at the greater curvature of stomach, and the pinkish hue of the

* See note, Beck's Med. Jurisp., v. ii., p. 52.

muscles about it. But it seemed all these might be due to other causes; hence the case was dismissed.

RUPTURE OF THE TENDON OF THE RECTUS FEMORIS MUSCLE.

By R. O. Mason, M.D.

Wm. D——, æt. 51 years, a policeman, temperate, having a tendency to corpulency, while patrolling his beat at three o'clock on the morning of January 4, 1860, slipped with his right foot on a spot of ice, bringing the whole weight of the body suddenly upon the left leg. Something in the limb "gave way," as he expressed it, "with a report like a pistol," and he fell heavily upon the ice. He was soon picked up, and finding he had no control over the injured limb, was assisted to the Station-house. I saw the patient half an hour after the accident. He was sitting in a chair, not complaining of any pain, and without any apparent deformity. On examination I could detect neither fracture nor dislocation. Being assisted to rise he could stand and even bear his whole weight upon the injured limb without pain, but could raise the foot from the floor only by elevating the whole limb and pelvis, and could move it forward only with a swinging motion, describing a sort of semicircle.

On examining more carefully in the vicinity of the knee-joint a sulcus was discovered, one inch and a half above the upper border of the patella, and wide enough to contain two fingers. Straightening out the limb and passing the fingers firmly along the rectus femoris, the muscle was found perfectly relaxed, and it was evident that the continuity of the tendon was broken, the ends of the fragments being distinctly felt both above and below the depression.

Six hours after, the limb was put up with a straight splint underneath reaching some distance above and below the knee-joint, and two short splints, one upon the muscle above the rupture and the other below the patella, all well padded; the former having a firm broad compress attached to it to act upon the muscle. Each of these was fastened firmly to the long splint underneath, and also to each other. Patient was then kept quiet in bed for four weeks, after which he was permitted to sit up, with the splints still adjusted, being relieved from them occasionally, however, and having the limb gently rubbed. At the end of eight weeks the splints were entirely discontinued, and the patient allowed quietly to resume the use of his limb. A firm callus now occupied the place of the former sulcus.

From that time the muscle rapidly regained its power and function, and now, one year after the accident, the patient knows no difference in the use of the two limbs, excepting a little pain and stiffness after unusual exposure, or sudden and severe changes of the weather. I have given the case simply on account of its rarity, thinking it might prove of interest at least to some of your numerous readers.

Reports of Hospitals.

NEW YORK EYE INFIRMARY.

GLAUCOMA—HANCOCK'S OPERATION FOR THE DIVISION OF THE CILIARY MUSCLE—RESULT SUCCESSFUL.

By F. J. BUMSTEAD, M.D.

Mrs. M., a widow, aged forty-three, who supports herself with her needle, applied at the Infirmary, November 16, 1860, for an attack of acute glaucoma in the left eye, supervening upon chronic choroiditis of several years' standing, and sympathetic disease of the opposite eye.

Her present attack commenced without apparent cause other than excessive use of the eyes six weeks ago; since which time she has suffered excruciating pain in the globe and temple, and has been reduced to an exceedingly debilitated condition by loss of sleep, and the low diet, depletion, and seclusion injudiciously directed by her attending physician.

Upon examination, the left eye is found to be abnormally hard to the touch; its vessels much congested; the cornea cloudy; and the pupil somewhat dilated and immovable. The sight of this eye was lost several years ago from the chronic inflammation above mentioned. An attempt to ascertain the condition of the choroid and optic-nerve entrance proves unsuccessful owing to the haziness of the cornea and lens, which obscures the deeper structures.

The opposite eye is intolerant of light, and watery, and its vision impaired; thus showing that its integrity is threatened, and that immediate measures are required for the preservation of sight.

Having been disappointed with the result in several trials which I had previously made of iridectomy, as advised by Von Graefe for the relief of glaucoma, I determined to resort to Mr. Hancock's operation for the division of the ciliary muscle, which recommended itself by its simplicity and the little danger attending it; and believing that the affection of the right eye was due to sympathy with the left, I resolved to operate upon the latter. I accordingly placed my patient under the influence of ether, and, with a Beer's cataract knife, made a section of the conjunctiva and sclerotica radiating from the corneo-sclerotic juncture, midway between the inferior and external rectus, obliquely downwards and backwards to the extent of about an eighth of an inch. This procedure required little more than a simple puncture with the point of the knife, the blade being buried an eighth of an inch beneath the conjunctival surface. The incision was followed by the flow of about a drachm of blood from the choroidal vessels, and some of this fluid gained entrance to the anterior chamber, but was readily evacuated by separating the edges of the wound with the point of a director. I now closed both eyes with isinglass plaster, and ordered two grains of quinine three times a day, together with a nourishing diet and an opiate, if required.

Upon seeing my patient the following day, I found that the effect of the operation had been almost magical. Since awaking from the influence of the anæsthetic, she had been entirely free from the pain which had harassed her for six weeks; she had had a good night's rest without the opiate; the intolerance of light had disappeared, and the eye was much less congested. Of course no improvement of vision was to be expected in the left eye, which had been blind for several years. Mrs. M. remained at the Infirmary for a week after the operation, during which time she continued to improve, and when she left the inflammation had entirely subsided, and the sight of her right eye was completely restored. I heard through her physician, in the early part of January, that she had continued well up to that time.

This is the first case, so far as I know, in which Hancock's operation has been performed in this country; and although a single trial is of course insufficient to justify a decided opinion, yet the successful result in this instance, taken in connexion with the cases reported by Mr. Hancock, affords reasonable ground to hope that this new method will prove of very great value in the treatment of one of the most dangerous diseases to which the eye is subject.

These favorable anticipations have been strengthened by the result of another case, which I was requested to see in consultation with my friend, Dr. Abram DuBois, on the 14th of February. The patient, a merchant of this city, about sixty-five years of age, lost the sight of his left eye from glaucoma several years ago, within a week after the commencement of the attack. At the time I saw him the same disease had appeared in the right eye; he was suffering very severely from circum-orbital neuralgia; and his vision was so obscure that he could with difficulty distinguish between small objects, as, for instance, between a pocket-knife and a pencil-case. He had been freely cupped

upon the temple the night before, with very little, if any relief. Hancock's operation was performed by Dr. DuBois without the assistance of an anæsthetic, and in fifteen minutes afterwards the pain had entirely ceased. On the second or third day the patient could read newspaper type, and within a week insisted upon going to his office and attending to his business. In this case, the aqueous humor escaped and slight prolapse of the iris took place, but there was no loss of blood.

In each of these cases the improvement in the symptoms following the operation might possibly be ascribed to the relief of the tension of the globe in consequence of the evacuation of the humors; but I believe that Mr. Hancock is right in his assertion that this explanation is insufficient, inasmuch as simple paracentesis oculi has never afforded an equal amount of benefit, and in several of the cases reported by this surgeon no fluid whatever has escaped from the eye. I do not propose, however, to discuss at present the theory of this and other operations recommended of late for the relief of glaucoma, but would refer the reader to the original papers of Graefe and Mr. Hancock, and to the able article by my friend, Dr. Noyes, in the number of this journal for February 2d.

American Medical Times.

SATURDAY, APRIL 6, 1861.

UNREQUITED MEDICAL SERVICES.

There appears to be a growing conviction that the maxim of the laborer being worthy of his hire, does not apply to the medical profession. While Legislatures fix with scrupulous regards salaries for state officers; while sheriffs, county-clerks, and even cormorant lawyers have their fees assigned to them, nothing is given, nothing is provided, nothing allowed the physician by positive enactment. That it is a high honor to be a physician all will admit; even among cannibals the medicine-man is looked up to as worthy to be reverenced; but we doubt whether any draft upon that honor would be accepted by a city bank in payment of a note, or by a city landlord in payment for a quarter's rent. It is true we never saw the experiment made, but we should be strongly inclined to argue *à priori* against its success. The time has gone by, if it ever existed, when honor alone will support a man in any profession, and the *quiddam honorarium* of the physician should always be considered as among those inherent professional rights which no body of men should deprive him of. The scriptures teach us that even the high and sacred office of the ministry is not to be an unrecompensed service, and that, on the contrary, "they who minister at the altar shall live by the altar," and there is no valid reason why physicians should not be rewarded, in the sense of being paid for their services whenever it can possibly be done.

We trust that the current of these observations will not be misunderstood, so far as to be considered derogatory of that spirit of humanity which makes it a pleasure with every physician to render gratuitous services whenever called upon. Far be it from us, who both believe and practise in this humanitarian creed, to deride its recognition in others. Nay, it is so far a sacred duty with the physician to *give* his services, where he knows he can expect no pay for them, that he has not yet learned the alphabet of medical ethics, who entertains any doubt upon this subject. And it has ever been a source of professional pride that the statistics of medical practice, since the earliest days of our art, show how generous and self-sacrificing have been its ministers in attending to the calls of suffering humanity; how great have been their sacrifices, and how earnest their devotion to the welfare of their fellow-men. Against gratuitous services rendered to and required by individuals in private practice, there is no occasion—no right, in fact, to say aught. It is a duty and a pleasure to render them, and each will do—must do—in these things, according as his conscience prompts him.

But there is a different theatre upon which medical men are required to give their services, and where, in return, the honor of bestowing them is supposed to compensate them for the time and talent consumed. We allude now to our Hospitals and Medical Charities. It is surely not necessary for us to enter at large into any examination of the benefits accruing to students in medicine from attendance upon hospital cliniques, nor of the advantages presented to their teachers by the subjects illustrative of the text of their lectures, thus brought under their eyes and control. Such things are self-evident, and explain themselves. A clinical lecture is more easily and effectively delivered in a Hospital, than in the amphitheatre of a medical college. So far, then, as the *locus in quo* of the service thus rendered the Hospital, is at the same time a convenience to the professor who instructs his class thereby, he can justly expect no compensation, for he receives that from the students. And indeed a small tax as hospital fee, charged students as a return for additional advantages and opportunities afforded them, ought to be more generally adopted.

The main point of our inquiry therefore becomes this, viz. Should the hospital staff be paid for the services rendered by them, and if so, by whom?

No one, we fancy, be he layman or physician, doubts the value of the medical services publicly rendered in our various institutions throughout the year. To say that they are worth nearly a million of dollars, is simply to assert what is susceptible of most easy demonstration. Bestowed as they are by some hundred or more noble-spirited men from year to year, they have become so much a matter of fact, as to excite no remark, and evoke no special gratitude from the public. Let, however, any merchant whose easy gains are earned by no personal risks or discomforts, present a fifty-dollar bill to any public institution, and behold the special vote of thanks instantly emanating from the Board of Trustees, and the great care taken that the Treasurer shall not omit to notice in suitable capitals the name of this generous patron, in his next annual report. But the physician or surgeon, who visits the institution every day for weeks and months, and spends an hour or two there, carved from the treasury of his private practice, what public thanks or mention does he get? Why, if a body of merchants equal in number to the staff of our Hospitals, were each to present a hundred dollars a month to such an institution, they would not equal by half the value of the services medically rendered during the same time by each and every member of that staff. And while laymen would receive some *quid pro quo* for such manifestations of generosity, the practice of which does not take them from their business one single hour, nor interfere with the current of their daily gains, the medical man turns his back upon the lucrative

call, in order to attend to the performance of gratuitous services. As between him and his conscience, this may be right; and the still small voice within may more amply reward him by its approbation, than do the thanks and newspaper puffs, which laud mercantile generosity to the skies. But as between him and the public at large—it is not right. Some compensation, it need not be large, ought to be given to the medical staff of our large hospitals, and that compensation should come from the state or the county where the services are rendered. There might be some conditions attached to the salary to meet particular degrees of service, but no services should be considered as adequately remunerated by the simple film of honor which compels and covers their rendition.

The doctrine of gratuitous services as a necessary appendage to practice in the liberal professions is only an inherited myth, and has long been laughed out of the ethics of every vocation, lay or clerical. Ministers and missionaries receive salaries; lawyers have their statutory fees; and physicians when attached to hospitals, and daily, for many months in the year, rendering exclusive services to hundreds of *pay-patients* in their wards, have certainly earned, and of consequence merit some compensation. It is idle to talk of the *honor* of the service, and equally cruel to say that it is their duty to do it. Every man's duty to others is limited and subordinated to his duty to himself; *semper tibi proximus esto;* and since no one can relieve all the misery in the world, and in attempting it would only impoverish and wrong himself, so it is a sufficient answer to say that the private practice of every practitioner generally makes a heavy enough draft upon his time and talents to meet every requirement of philanthropy.

We believe, therefore, in the obligation incumbent upon the state or county to remunerate, in some slight degree, those who do so much patriotic service in lightening the burdens of pauper-sickness which ever rest upon the state. We believe that, although many men do work well without pay, all do work better with it. Pay is oxygen to both muscular and intellectual exertion. It is a stimulant to effort—a tonic to flagging energy—the discutient and deobstruent of inertia, and the placebo for all services rendered. And it would be a source of pride to the community to know that, while in its hospitals pay was exacted and received from a large proportion of patients, thus exhibiting the doctrine of remuneration as towards the institution, those who formed its chief bulwarks and ministers—the souls and spirits without whose ministrations of skill neither walls nor beds, neither food nor shelter would bring relief to diseased humanity—that these noble men are not sponged upon under a false standard of honor for services which the world at large stands ready to reward with an unstinted hand. Let the Legislature, therefore, inaugurate a new day of justice towards those who, with so much self-denial, are daily serving the public, and daily, in the truest exemplification of Christian grace, performing

> "A thousand, nameless, unremembered acts,
> Of kindness and of love."

THE WEEK.

We have received a circular from the "Miami Valley Medical Association," Ohio—a Society which "embraces the Great Miami Valley." It was organized in 1857, and incorporated in 1860, with power to hold property, grant diplomas, and acquire facilities for scientific investigations, etc. The trustees of this Society have determined to establish a library and cabinet, and "in order to carry out these laudable designs," they make the following requests:—

"1. That the publishers of medical periodicals donate one copy of each number regularly, as published, to our library, which numbers are to be carefully kept by our librarian, and at the close of each year to be neatly bound at the expense of the Society, and exhibited to the members and public as a specimen of said publications. 2. That the publishers or authors of medical books, donate one copy of said books to the library of said society, for the purposes named above. 3. That the publishers of literary and scientific journals and books donate the same as requested of publishers of medical journals, for the same purpose. 4. That all who have anatomical preparations or specimens of Osteology, Geology, Mineralogy, Zoology, Ornithology, Entomology, &c., which they can spare, will please donate to our cabinet. In return, the Society will publish annually a complete catalogue of all donations, with the names of donors, and give it an extensive circulation; and all donors will thereby acquire a regular honorary membership of the Association. Thus by a slight gift on the part of each donor a large and valuable collection of literary and scientific publications will be collected and neatly preserved for a good and valuable purpose. Also, a beautiful and useful cabinet can be accumulated, where the donors may regale themselves at any time by a visit to our attractive and instructive collections."

We heartily approve the objects of this Association, while we as heartily dissent from the proposed mode of carrying "out these laudable designs." We venture to say that every member of this Association is opposed to free physic, because what costs nothing is lightly valued. We are in like manner opposed to free periodical medical literature, and for the same reasons. The subscriber who regularly *pays* for his medical journal derives far more benefit from it than one who receives it gratuitously, or is a delinquent. Again, the members of this Association are, we doubt not, opposed to gratuitous medical service, except as an act of common charity, because every man is entitled to compensation for his labors. For the same reason we are opposed to the gratuitous distribution of medical periodicals to medical men and associations. If there is any class of laborers in the field of medicine which deserves earnest, cordial, and unqualified pecuniary support, for services actually rendered, it is that devoted to the publication of medical journals. These periodicals are absolutely essential to the growth, the integrity, and even the existence of the profession, and yet they can never be remunerative to the proprietors, because their publication is expensive, their circulation limited, and *their losses from delinquent subscribers excessive.* There is no more humiliating aspect of the morals of the profession than that which the failure of some of our best medical journals exhibits. The touching appeals which they make to delinquent subscribers who have been the cause of their failure, and which ought to call forth generous contributions, are too often entirely unnoticed. During the past year several excellent journals have, for this cause, been compelled to discontinue.

These are our reasons for declining to become donors to this, or any other Society, whose organization is not for purely charitable purposes. One hundred dollars will furnish the Society with all the American medical journals, and if it is incapable of raising that amount, annually, towards a library, it is not a safe guardian of such collections as it proposes to make. It might be gratifying to the

proposed donors to such Library and Cabinet to "regale themselves at any time by a visit to *our* attractive and instructive collections," but such an event should be deeply mortifying to the members of a medical Society "embracing the Great Miami Valley."

While, therefore, we withhold the desired donation from a Society that ought to purchase whatever is needful to its improvement, we would not have it inferred that we decline to furnish this journal as a matter of charity, gratuitously. If the President will furnish us satisfactory proof that any members, especially young practitioners, are unable, after practising rigid economy, to pay for this journal, we will send them free copies.

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A MEETING was recently held at Romsey, England, presided over by the Prime Minister, Lord Palmerston, for the purpose of considering measures for the improvement of the dwellings of the working classes. One of the speakers alluded to the Hastings Cottage Improvement Society:—

"It has now been in operation for about four years, and from its humble commencement by three or four resident gentlemen, who each contributed £100, and forthwith purchased a few cottages, which then were immediately put into a proper condition, and have been tenanted ever since, it has steadily advanced in extent and prosperity to the date of its last half yearly report in October, when the number of its shareholders was between fifty and sixty, and the capital invested was about £12,000. A dividend of six per cent. has been paid yearly, and, after discharging all of the expenses connected with the purchase and improvement of the property that has been bought, a reserve fund of nearly £300 has been accumulated."

This society, it appears, does not build new cottages, but aims to render those purchased more habitable, by the introduction of sanitary improvements, such as ventilation, drainage, cleanliness, supplies of fresh water, &c. The effects of this society's operations extend beyond the limits of their own possessions, for the neighborhood is influenced, and greater attention is given generally by the inhabitants to their homes. Lord Palmerston remarked, at the meeting referred to:—

"Nobody should run away with the notion that nothing can be done to improve the dwellings of the poor, short of building cottages which they may think too expensive for their means. Depend upon it that a very great deal can be done at a moderate expense towards making old cottages decent and habitable."

We are not surprised to learn that "the success of the Hastings scheme is mainly due to the clear-sightedness and unflagging zeal of an accomplished physician there, who, amid professional and literary engagements, has found time to supervise and direct its operations, with much signal success." Will not physicians residing in our larger towns, where the common laboring or manufacturing classes are generally compelled to occupy houses built without regard to the health of the tenant, recognise a duty which they, as versed in the laws of health, ought to discharge without delay? A society organized on the plan of the Hastings association, is remunerative to the shareholders, to an extent to render an investment in its stock desirable to capitalists.

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RUSH MEDICAL COLLEGE, CHICAGO.—At the recent commencement of this College, thirty-six students received the degree of M.D. The Valedictory Address was given by Prof. Allen.

Reviews.

1. ANNUAL REPORT OF THE BOARD OF HEALTH OF THE CITY OF BALTIMORE. Baltimore, 1861. pp. 32.
2. REPORT OF THE BOARD OF HEALTH OF PHILADELPHIA, FOR 1860; SANITARY AND STATISTICAL. In accordance with an Act of the Legislature, approved March 8, 1860, for the Registration of Births, Marriages, and Deaths. Philadelphia, 1861. pp. 87.
3. ANNUAL REPORT OF THE CITY INSPECTOR OF THE CITY OF NEW YORK, FOR THE YEAR ENDING DEC. 31, 1860. New York, 1861. pp. 264.
4. ANNUAL REPORT OF THE HEALTH OFFICER OF BROOKLYN, FOR THE YEAR 1860. Brooklyn, 1861. pp. 64.
5. REPORT OF THE HEALTH PHYSICIAN OF THE CITY OF NEWARK, TOGETHER WITH REPORTS OF THE DISTRICT PHYSICIANS TO THE BOARD OF HEALTH. Newark, 1861. pp. 35.

(*Continued from page* 214.)

THE Sanitary System of the City of New York is an anomaly. The Mayor and Common Council, "whose fame has gone out through all the earth," are the Board of Health. A Resident Physician, a Health Commissioner, the Quarantine Health Officer, the City Inspector, the Presidents of the two branches of the Common Council, and the Mayor, constitute a ministerial body called the Commissioners of Health. The City Inspector is the constituted head of the Sanitary Department. He nominally has charge of all that relates to sanitary inspection and civic cleanliness, the supervision of markets and inspection of all articles sold therein, together with all that relates to scavenging, offal removal, inspection of weights and measures, and the registration of births, marriages, and deaths. With all its checks, counter-checks, and complexities, this *insanitary* arrangement costs the city a round half million of dollars every year, and at the same time serves to perpetuate a state of public insalubrity that gives to New York the ignoble reputation of the highest death-rate of any large city in the civilized world.

The Annual Report of the City Inspector makes imposing pretensions. Its main design is to cover the rottenness and incompetency of the Health Department of the City Government. But the statistics of the Bureau of Registration furnish ample testimony to the criminal inefficiency of the system, which every year requires a ponderous volume to show how and why the inhabitants of this favored city are destroyed at the rate of from thirty to thirty-five in every thousand annually. But it is manifest that the City Inspector is utterly ignorant of the real causes of our excessive mortality, though his Report does contain some sensible statements respecting stables, swill-milk, and garbage. It is when he attempts to speak of the leading sources of insalubrity that the insufficiency of a mere huckster's education appears in the Chiefs of the Sanitary Bureau. Listen to the Inspector's suggestions on the subject of the unparalleled mortality among children in our city.

"And how is this state of things, which marks with shame the City of New York, to be remedied? The power of remedy does not rest with me, nor in the department over which I have the honor (?) to preside, *but is to be found in the erection of hospitals.*"

This is a fair illustration of the lamentable stupidity which characterizes all the plans and suggestions that emanate from the City Inspector's department; and as we have noted some of these things in a former number of the TIMES, we will not inflict further quotations upon our readers, but will only refer to some of the statistics, hereafter, in a summary table of comparison.

There is a feature of this Report which is truly creditable. We refer to the admirably arranged and very complete Meteorological Register, which we learn was recorded and prepared by the Resident Physician of the Eastern Dispen-

sary, Dr. Jonas P. Loines; complete readings of the barometer, hygrometer, temperature, wind, and weather being made thrice daily, with daily summaries of their *means*, &c. A noticeable peculiarity of our New York climate is observed to be an extremely wide range of the degrees of difference between the wet and dry bulbs of the hygrometer, with only a moderate diurnal range of temperature; e. g. on the 28th of June the readings were, at the hours of

	6 A.M.,	and 2	and 10 P.M.
Thermometer . . .	71°.	84°.	81°.
Difference in bulbs . .	9.	18.	8.

For a maritime city the atmosphere of New York is remarkably dry, the mean temperature of evaporation unusually uniform, the average amount of cloud a minimum for the Atlantic coast, and the diurnal range of temperature very moderate; thus constituting a climate unsurpassed for its salubrity. Shame be to the municipal officials who blindly persist in making gain by death and disease in such a city.

We have already mentioned that the annual expenditures of the Municipal Bureau of Health and Cleanliness amount to half a million dollars; and even this enormous sum fails to secure either cleanliness or salubrity. A former chief of the department once gave his testimony to the fact that the loss to the people by preventible disease in this city exceeds *thirteen millions* of dollars annually. To this should be added at least another million for needless burdens inflicted by our quarantine system. This is the cost of not being permitted to have medical knowledge and sanitary science in the Health Department!

That a Department of Health, which by virtue of its power, patronage, and corruption, can on a day's notice raise from ten to fifteen thousand dollars to prevent legislative reform of its abuses, should make the following announcement of its estimate of sanitary science, is certainly very natural:

"Nor is it necessary for the further efficiency of this department that it should become the *nursery of students of medicine*—a plan suggested by the physicians of this city, who seem anxious to convert the department into a medical seminary."

We gladly turn to the examination of the Brooklyn Health Officer's Report. Dr. Jones has evidently endeavored to discharge his duty as a medical officer, and in the very opening of this budget of statistics he declares to the mayor and council that "the bill of mortality and death rate is too large."

Brooklyn has its Health Officer, who is a physician appointed by the Mayor; but the Board of Health, which is constituted by the Common Council, retains in its own hands all the power of enforcing and devising sanitary regulations; therefore that official holds the position of a registrar of vital and mortuary statistics and scientific adviser to the city fathers.

It is not the fault of Dr. Jones that last year one person out of 36.7+ in Brooklyn became a silent inmate of its cemeteries. The health officer has been ignobly deprived of all power and means for protecting and improving the public health:—even the few health wardens of his predecessor have been taken from him.

Among the many valuable suggestions contained in Dr. Jones's Report, are some practical hints relating to the economics of medical relief to the poor. He shows that the average cost of maintaining each patient in the Almshouse Hospital of Kings county, is $16.50; in the Brooklyn City Hospital, $14.89; while in the five Dispensaries of New York, the cost of each patient is *less than eighteen cents.* The argument he presents in favor of a liberal and systematic support of public dispensaries is conclusive. And he justly says:—

"Abolish dispensaries, and our city, before anything could be substituted in lieu thereof, would be converted into an immense lazaretto, and our death rates would appal the strongest record and stoutest hearts."

In adopting and recommending all the practical details of the "*Metropolitan Health Bill*," the Brooklyn health officer pays a merited compliment to the sanitarians who have brought forward that measure. How different from the cynical and base insinuations of the New York inspector! May the "*Metropolitan Health Bill*" become a law, and may the Brooklyn health officer continue to serve the public under its comprehensive provisions.

This Report has some important suggestions regarding small-pox and its prophylactic. And as its statements on the subject of providing fresh virus from the cow have evidently been misunderstood, as they are, by a strange lapsus, mis-stated in the report, we hope Dr. Jones will be pleased to favor our readers with a special statement of his views on that important subject. He believes it advisable to keep cows continually (successively?) under inoculation for the purpose of supplying the vaccine virus. This moot question is not to be settled by ridicule, nor by the foolish assertions of the National Vaccine Board of Great Britain that the vaccine lymph offered by them preserves its original efficiency after passing "through nearly a million of subjects successively." Dr. Estlin of Bristol, who has given much attention to this subject, and at various times provided fresh virus from the cow, has shown how unworthy such statements are.

But we must hasten to notice the evidences of interest in health by the public authorities of the manufacturing city of Newark. Situated at the head of a narrow bay that is flanked by malarious marshes, the city of Newark is not most favorably located for salubrity. And we find in this Report that intermittent fever stands only fifth in the long catalogue of diseases reported by the Dispensary Board. Bronchitis gave the highest ratio in that catalogue, diarrhœa second, and rheumatisms third.

The Newark Board of Health consists of the Mayor, three Aldermen, and the Health Physician; and that Board, acting with the Board of Dispensary Physicians, constitutes the Dispensary or Hospital Board. The constitution and functions of these Boards are unique, and they appear to work harmoniously and efficiently. The essential and more constant labors of the Board of Health are merged in those of the Dispensary Board. This is as it should be, and if we do not misjudge, that busy city will soon have one of the most efficient and economical sanitary systems that can be found. It is a working plan, and is manned by competent medical officers. The Health Physician, Dr. Nichols, speaking officially, says—

"The Board of Health have a plain duty to fulfil. They are the custodians of the public health. It is their duty—like that of the true physician—not so much to cure disease as to prevent it. If any severe epidemic occurs in our midst, through our neglect or inefficiency, much, much will be required at our hands, by an indignant populace. The building of tenement houses, the erection of workshops, the disposal of the dead, are as much under our charge as that of the disposition of offal, or the care and vigilance exercised that no epidemic gets a foothold among us. Let us proceed judiciously, yet firmly, in the course marked out by the hand of sanitary science."

This is the true faith of physicians and sanitarians, and the Newark Sanitary and Hospital Boards show their faith by their works. We are glad, also, to see that those Boards are alive to the importance of providing enlarged hospital accommodations in their city. Strange it seems that a city of more than seventy thousand inhabitants, largely mechanics, should have possessed no hospital until these Boards were organized a year or two ago.

Deferring our notice of the Sanitary Returns of Boston, Providence, and the southern cities, we will also defer the presentation of a comparative summary of the vital statistics of the several cities whose Health Reports have reached us. For the sake of the reputation of New York and Brooklyn, we would gladly omit that summary, for it shows, by mathematical demonstration, that in this emporium of the nation, death finds the largest harvest—the highest ratio of mortality of any cities in Christendom.

Progress of Medical Science.

Chlorate of Potash in the Treatment of Phthisis, Scrofula, and Other Diseases.—Dr. E. J. Fountain, of Iowa, reports in the American Medical Monthly, several cases treated by the chlorate of potash in corroboration of his belief that the unpleasant effects which some have observed to follow its administration are due, in a great measure, to the impurity of the drug employed, and in some degree to an injudicious method of administering it. Since he has commenced using the French preparation of absolute purity, he has not known a single instance where it has produced either diarrhœa or loss of appetite. A brief abstract of his cases will illustrate the difference in effects of this and that ordinarily sold by druggists.

Case 1.—Physical signs plainly indicated tubercles in both lungs, with cavities in the left. Prescribed chlorate of potash in drachm doses, three times daily, when increase of appetite, diminution of expectoration, relief of oppression and dyspnœa, and general improvement followed. If the treatment was suspended for a few days the unpleasant symptoms were aggravated, but soon subsided on resuming the medicine. The treatment was continued for over two months, "at no time producing either diarrhœa, nausea, or a sense of loathing." At length the patient was so much improved as to venture upon a long walk, which so overtasked her strength that she never entirely recovered from the extreme prostration which followed. Soon after this, the chlorate began to disagree with her, when it was found that the last package she obtained was inferior to that previously employed. The druggist being out of the French preparation had obtained a supply from a neighbor, which proved to be impure, having a nauseous taste, offending the stomach, and did no good. The following was his method of prescribing.—Potass. chlorat. pulv. ℥ vj. ft. ch. No. xvj., one powder to be taken each day in three doses, each extemporaneously dissolved in a sufficient quantity of hot water; the first dose in the morning to be taken after breakfast.

Case 2.—Phthisis.—Ordered ℥ ij. of saturated solution (one drachm of the chlorate) three times a day, after meals; rapid improvement followed, with corresponding change in the physical signs; medicine tolerated for several weeks, increasing the appetite and powers of digestion. Case 5.—Chronic eczematous eruption, for which was prescribed a wine-glassful of the saturated solution, morning and evening. A few weeks afterwards the patient stated that he felt greatly relieved of a pulmonary difficulty which had been gradually increasing upon him for years, which, however, he had not mentioned when he first came under treatment; and having no previous knowledge of the properties of the chlorate, there was no room for deception.

Case 6.—A girl aged 12, with fœtid discharge from the ear, since the age of 11 months. Iron, iodine, cod-liver oil, iod. of potassium, had been prescribed at different periods without any material benefit. After taking three tablespoonfuls of the saturated solution, morning and evening for about two weeks, the discharge entirely disappeared.

Cases 7, 8, 9, 10, and 11, were generally of a strumous character, and improved under the same treatment, the medicine not offending the stomach, but on the contrary improving the appetite and digestion.

Case 12.—Carbuncles. Prescribed half an ounce of the chlorate daily, and in a few days was informed that it tasted repulsive, produced diarrhœa and nausea. Upon examination this was found to be impure, and another package ordered from a place where none but the French chlorate is kept. This was not nauseous, produced no diarrhœa, and at the time of writing the patient was recovering on its use. Case 12 is a complete recovery of a bad case of morbus coxarius in a little girl of six years. A tablespoonful of the sat. sol. was given three times a day until the cure was effected. Dr. F. concludes his paper by insisting upon the necessity of obtaining a pure article, and not unjustly condemning it, because there is much that is impure in the market. He does not pretend to say that none but the French chlorate is perfectly pure, but he knows of no other that he can depend upon. "It is in small scales and flakes, of brilliant appearance and pearly whiteness." In using it, he makes a saturated solution in hot water, which cooling, some of the salt is precipitated, leaving in solution about one ounce to the pint, or one drachm to two ounces, which he prescribes in appropriate doses without further dilution.

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

(*Concluded from page* 200.)

FIBROID DEGENERATION OF THE UTERUS, STOMACH, AND OVARIES, PERFORATION OF UTERINE WALLS WITH THE SOUND, AND HEALING OF THE WOUND WITHOUT PERITONEAL INFLAMMATION.

Dr. Krackowizer presented three specimens, consisting of a stomach, uterus, and left kidney, which had been taken from a woman who died three days before. He gave the history as follows:—I was called to see a lady in consultation on the 21st of December. She was thirty-five years of age, and had always been healthy. She had an older sister who had been married for a good many years, and has seven children. She herself was delivered five times, and it appears that on each delivery there was a transverse position which necessitated the performance of version; when the child was still-born. Her physician being aware of that fact, during her last confinement was prepared to effect the turning as rapidly as possible, and succeeded in bringing away a living child. She was determined to keep that child, and so endeavored to place it in the best possible condition to guard it against the usual diseases of childhood. Accordingly she nursed it for twenty-two consecutive months, and weaned it only at the commencement of last September. Of course, during the last month of the time, she became very much debilitated. She had seen what she thought to be her menses, in April last, but never since. Just previous to the weaning of her child, she noticed a swelling of the cervical glands on the left side; at the same time she complained of pain in the pit of her stomach, and she was taken with what appeared to be intermittent fever, which disease rapidly yielded to the appropriate treatment by quinine. She appeared to be somewhat better during the month of September, yet she would have these apparent attacks of intermittent fever irregularly, and they became rebellious to treatment. She became much weaker, her appetite became capricious, vomiting occurred from time to time, and she considered herself pregnant. Her physician was inclined to think so, and was consequently indisposed to enter into a regular treatment for her complaints. She grew worse, and he felt that he had to make a more thorough examination; placing his hand upon the abdomen found a tumor above the pubes, and thought it to be an impregnated uterus, but stated to her that he could not make a sure diagnosis unless she would consent to a vaginal examination. It appears that during November and the first half of December, she had been under the hands of an empiric, the consequence of which was that she ran down very rapidly. The attending physician saw her again on the third week of December, and she was then in the condition in which I found her when called in consultation. She was extremely emaciated, her countenance was sallow and of a greenish color, there was constant hectic, the vomiting was very frequent, but consisted of nothing more than the contents of the stomach. She could retain only the mildest nourishment. The cervical glands in the upper and lower

triangle were enlarged, but not hard; they felt very much like hypertrophied glands. The liver did not seem to be enlarged in size, and the spleen could not be detected by palpation nor percussion. The pit of the stomach did not protrude, but there was a fixed pain in that locality which did not permit any rough handling or pressure; consequently no tumor was detected. The lungs and heart were healthy. To all appearances the left of the hypogastric region was taken possession of by a tumor somewhat rounded in shape. The more thorough examination of the tumor and adjacent parts was delayed until a vaginal examination could be made. On introducing the finger, the os felt natural in size; cervix somewhat shortened but not enlarged, and there were several small rounded tumors imbedded in its substance, and underneath the mucous membrane where it reflects from the surface of the vagina. These tumors were about the size of a hemp-seed or small pea; they felt equally round and hard, and seemed to be imbedded half way in the substance of the neck, pushing forward the mucous membrane. On introducing the speculum, the color of the cervix and vagina was found to be normal, with the exception of these small tumors, which presented a yellowish appearance. The mucous membrane as it enters the os was somewhat reddened and swollen, and a sero-purulent substance flowed out from the opening. *On introducing the uterine sound it passed with great facility through the internal cervix, a distance of six inches.* I felt the knob very distinctly through the abdominal walls, and the tumor was felt to the left of it. On handling the tumor it could be moved independently of the sound in different directions. I must mention that the tumor did not elicit any pain nor did the sound produce any unusual unpleasant sensation. On examining through the rectum, a hard nodulated tumor was discovered behind the uterus, which seemed to be in connexion with the one above the symphysis. Keeping the finger of one hand on the cervix and making depressing motions through the abdominal walls with the other, these motions were sensible to the finger in the vagina. The diagnosis I was somewhat doubtful how to make. There was certainly painted on the patient's looks the color of deep cachexia, as we see it in malignant disease. There was this swelling of the cervical glands, there was a tumor apparently unconnected with the uterus, or if connected, only by a pretty distinct pedicle above the symphysis. The finger and speculum revealed the existence of those small rounded tumors in the cervix, which, from their feel and their color, favored the supposition that they were fibroid in character. From this I concluded that the larger tumor was of this character. I strengthened this view by the fact that the abdominal tumor was not painful, and could be moved in all directions. I hence concluded that such was the character of the tumor, that it had pushed the peritoneum before it, and had become somewhat pedunculated. The enlargement of the cavity of the womb I thought I might attribute to the enlargement of the uterus itself, as is generally the case when it is the seat of such growths. Although I was somewhat surprised that the sound should enter the cavity with such facility, I thought it was not improbable the woman was pregnant, and that the sound had entered the cavity between the walls and the membranes, and I mentioned to her attendant that if such were the case, she would probably abort in a few days. Having made this diagnosis, we still thought that there was a possibility of the existence of some hidden cancerous disease which produced the cachexia, and as a secondary affection, the enlargement of the glands of the neck. Merely palliative treatment was instituted. The symptoms, as the case progressed, did not differ from those already described, and the patient sank gradually, and died on the 20th of January.

Autopsy.—Yesterday forenoon the post-mortem examination was made. The abdominal cavity only was opened. A tumor was noticed to the left of the median line of a more or less rounded appearance, whitish color, and cartilaginous feel. I must state that no abortion took place, and the woman never lost any blood from her genitals. To my utter astonishment I found the uterus of a normal size, and the walls apparently as firm and unyielding as we ever see them. It was difficult for me to explain this. The specimen showed that *the sound had passed through the fundus*, and *the wound had healed without the least trouble.* This tumor was found adherent to the left fallopian tube, which ran in an oblique direction upwards and outwards, where it was bound down by adhesions. It also sent a prolongation, a sort of bunch, down in the recto-vaginal fossa, which was the mass felt through the rectum. No ovary was found upon this side. On the right side there is a small tumor of the same consistency, only a little more lobulated, and which was situated a little outward, and behind the uterus. The nodules could still be felt at the point of reflection of the mucous membrane from the neck of the womb to the vagina. On making the examination of the stomach and liver, it was found that the commencement of the transverse colon, and the pylorus, were fixed by false adhesions to the transverse sulcus of the liver, and by this adhesion the transverse colon had somewhat bulged out, and expanded by gas, and pressed so much upon the organ that it had squeezed out its liquid contents, and gave it an almost membranous appearance. On slitting open the stomach, its walls were found infiltrated, but it was seen that the mucous membrane was nowhere in an ulcerated condition, although there were left cicatrices upon the surface. The membrane was also somewhat protruded on account of the nodules underneath. The pelvis of the left kidney, probably from pressure on the ureter, was very much dilated, and so were the calices. The substance of the kidney proved that there was some atrophy of the granular substance. The post-mortem showed an error in the diagnosis that, whereas the tumor was held to be uterine, pedunculated, and fibroid in character, it was a degeneration of the ovaries. The degeneration of the stomach was suspected during life, but for reasons that I have stated could not be felt. On cutting open the tumor it was found to be hard, and gave that peculiar "crying noise." The left ovary was of the same character, and upon one spot in the midst of this substance was imbedded a still more resistant and elastic nodule, which had all the appearance of a fibroid tumor. On splitting open the uterus, it was found that its walls were marked by a whitish substance which showed the commencement of fatty degeneration. These white marbled spots seemed to surround the laminæ of the vessels. The uterine cavity had the usual length of three inches; there were then three inches wanting where the sound had passed in some other than this cavity. The specimen showed that the sound passed through the uterine walls. Near the left cornua of the uterus is seen a funnel-shaped opening which enters the substance of the uterus, and conducts to a spot on the peritoneal lining of the fundus a little posteriorly, which is marked by a small reddish spot like a cicatrix. *There are no traces of peritoneal inflammation in the neighborhood, neither does there seem to have been any effusion of blood attendant upon the injury.* I thought at first that I had been mistaken in my diagnosis, in every point, by the seat as well as the character of the tumor; I thought, when I had finished the post-mortem examination, that this was hard cancer; that it might have originated at the same time in the stomach, and both ovaries, and that the affection of the cervical gland was secondary; but after microscopic examination, I am of the opinion that this idea of the cancerous degeneration of the tumor cannot be sustained. If we understand by carcinoma, a new cell formation, with a tendency to multiplication, then this is not cancer; for it is formed entirely of fibroid cells. It consists of elongated fibres with nuclei, which are either round or elliptical. I have taken one specimen from the stomach, and found exactly the same arrangement of microscopic texture; two specimens were also obtained, one from immediately beneath the mucous membrane, and another from the muscular striæ. In none of these could I detect a single cancerous cell.

A HISTORY OF THE MEDICAL SOCIETIES OF NEW YORK CITY,

READ BEFORE THE NEW YORK MEDICAL UNION, DEC. 1860.*

By ALFRED L. LOOMIS, M.D., President of the Society.

GENTLEMEN :—One of the most important events in the history of modern medicine was the formation of the Royal Society of London, in the year 1645—the first medical society constituted out of Italy. In the eighth century, all learned societies were sacerdotal in their origin, being connected either with mosques, monasteries, or collegiate churches. In the thirteenth and fourteenth centuries they appeared as universities, yet under the protection and control of the church. In the sixteenth and seventeenth centuries, medicine had so widely extended its limits, that it required special institutions for its development. The theologians were still predominant in the universities, and fettered inquiry. Medicine wanted freedom. Hence, at the height of the great civil war, some of the most distinguished in the English medical world banded themselves with other investigators of nature, and established the Royal Society of London—"The head and home of modern medicine and natural science." At its foundation, practical and experimental medicine received its first impulse, and soon assumed its position as a distinct science —untrammelled by church or state. Kindred societies, purely medical in their character, were soon established, to *which* we owe much that has elevated and advanced our profession. But as I have neither time nor the material to give you true histories of their labors, I will rather invite you to medical societies, as they have existed in our own city. In which labor I have been greatly assisted by the venerable John W. Francis.

So early as 1742 and '43, upon the appearance of yellow fever, as described by Colden, a medical society was formed in New York, *in which* the medical faculty of Columbia College (then called King's College) was organized. No publications emanated from this society. In 1768, evidences exist, that there was a union among medical men to promote scientific medicine. But at that period, in order to secure the power to exercise the healing art, the candidates for that distinction made application to a county judge for permission to enter the list of doctors. This circumstance was unquestionably a reason why we have recorded, or hear so little concerning medical societies, until the formation of the Medical Society of the State of New York, in the year 1793, Dr. John Bard being its first president. Dr. Bard made his administration renowned by his ability, his firmness, and his great decision, that *yellow fever* was then prevailing in New York. From the recorded evidences, it appears that a suspicious case of fever was reported to the constituted authorities (at that time composed of gentlemen of the legal profession); the matter was referred to the Medical Society of the State of New York; the members were divided—a large majority affirming that the case was only one of common bilious fever. Dr. Bard had prepared himself for an answer, by previous ocular inspection. "Whatever may be the decision of this meeting," said the Doctor, "the disease is yellow fever, such as I have seen fifty years ago; and, gentlemen, you will all be convinced within a few days." His prophecy was fulfilled; for the pestilence of 1795 is recorded in many volumes. This Society published many papers on yellow fever, and a volume of Transactions.

We find few or no details concerning medical societies in the city or state after this period, until 1807, when, by special enactment of the Legislature, county medical societies were formed throughout the States; also the State Medical Society, which was organized principally by the exertions of Dr. John Stearns, a man of erudition, and a writer of ability. This year was also rendered remarkable by the establishing of the College of Physicians and Surgeons, upon the recommendation of the regents of the University. The County Medical Society of New York took in by wholesale, all existing practitioners of medicine in the city, as members. The famous Nicholas Romayne was elected its first president. This organization still exists, in common with those of other counties; and though it has proved inefficient for its great designs, it has published a System of Medical Ethics, and several reports on fevers and pestilence, of value.

The societies I have thus far recorded, were the offspring of legislative enactments; but many formed by voluntary association have existed, and do still exist.

The first in order was the American Æsculapian Society, established by the students of the medical faculty of Columbia College, in 1806. Its duration was for six or seven years. The avowed object of the organization was the promotion of medical and surgical science, by the reading of original papers, and by discussions on contested subjects. This Society published an annual report of its proceedings.

Next in order was the voluntary association called the Medico-Chirurgical Society, established in the fall of 1807, soon after the opening of the first course of lectures in the College of Physicians and Surgeons, when the talented Romayne (the first president), Dr. Miles, Dr. John Augustine Smith, Dr. Hosack, Dr. DeWitt, Dr. Bruce, and Dr. McNiven were teachers. This Society existed about twelve years, and published an annual report of its proceedings, which were, indeed, similar to those of the Æsculapian Society. Among its presidents are recorded Drs. Francis, Mitchel, and Hosack. The union of the faculty of Columbia College with that of the College of Physicians and Surgeons, led to the formation of no new medical societies.

In August, 1815, several of the then young members of the medical profession, viz. Drs. Valentine Mott, Samuel B. More, James C. Bliss, Joseph M. Smith, Ansel M. Ives, Edward C. Post, Henry Fish, Cornelius De Puy, and Guy C. Bailey, formed themselves into an association called the Physico-Medical Society. Dr. Valentine Mott was the first and only president of this Society. The Society existed five years. Its principal object was the reading of original papers. It published a large and valuable volume of Transactions, which met the approbation of Abernethy of London. In this volume is to be found Dr. Mott's paper on Pulsation in Epigastrio; Dr. Wright Post's Operation for Carotid Aneurism, reported by Dr. Mott—the first successful operation of the kind in this country; a Paper by Dr. Joseph M. Smith on the Efficacy of Emetics in Spasmodic Diseases, and many other papers of exceeding merit.

There is no record of the existence of any other Medical Societies until the year 1823, when the K. A. Society was established by Dr. Alex. H. Stephens, G. Smith, T. Cock, and Joseph M. Smith. This organization was secret in its character, of which there were branches throughout the United States. The mother chapter of this society was organized by Dr. Samuel Brown at Lexington, Kentucky. The avowed object of this society was the promotion of good fellowship in the profession, and the advancement of medical science among its members. Under its auspices the North American Medical and Surgical Journal, a quarterly, was published from 1826 to 1830, conducted by Drs. H. Hodge, Bache, Chas. Meigs, and LaRoche. This society still exists.

Next in chronological order, we find the New York Medical and Surgical Society, which was organized in 1834 at the New York Dispensary, by Dr. John Watson, J. G. Adams, H. D. Bulkley, and Swett. It held its meetings semi-monthly at the Dispensary until 1836, when it was reorganized in the library rooms of the New York Hospital, where for ten years its meetings were held, at which papers were read and discussions held on medical and surgical subjects. During this time it was eminently a working society, and published many valuable papers. In this society the first discussion on Homœopathy was had about 1842. It arose from a paper presented to the society by Dr. McVickar, which contained many mis-statements or

* Published at the request of the Society.

exaggerations in relation to the success of Homœopathy in the treatment of disease. A committee was appointed from the society, whose investigations and report led to the resignations of Dr. McVickar, Dr. Wright, and Dr. Ticknor. In the year 1844, the meetings of the society began to be held at the house of its members, and in a few years it became almost entirely social in its character; as such it still exists.

In 1843, the "Harveian Circle" was organized; a club having for its object social intercourse and the promotion of the professional advancement of its members. Its founders were Drs. Isaac Wood, J. Green, Underhill, Van Kleek, J. R. Wood, Goldsmith, and Rockwell. At the meetings of this society cases are related which have occurred in the practice of the members, and papers are read on medical and surgical subjects. A circulating periodical library is attached to this society, which is supported by a tax on each member. No publications have ever emanated from this organization.

During the summer of 1844, at the call of Drs. Sayre and J. C. Peters, there met at the house of Dr. Sayre, Drs. Thomas F. Cock, Markoe, Robt. Watts, Roberts, Tomes, Youngs, McNivens, and J. C. Peters, and organized the New York Pathological Society. For a time the meetings of the society were held at the office of Dr. Sayre, subsequently at the houses of its members. Since the autumn of 1844 its meetings have been held at the College of Physicians and Surgeons. The object of this society is the improvement of its members in Pathology, and in the Diagnosis and Treatment of diseases as founded on Pathology.

Its first president was Dr. J. A. Swett. Its monthly reports have been and continue to be published in the medical journals of this city. This society at present numbers 180 members.

At a numerously attended meeting of the regular practitioners in the city of New York, held December 12, 1846, at the Lyceum of Natural History, pursuant to a call from Drs. Alexander Stevens, Valentine Mott, and Isaac Wood, it was agreed that an association of all the regular practitioners of medicine and surgery should constitute an Academy of Medicine; the object of which should be to elevate the character of the whole profession, advance its interests, and increase its usefulness. The committee on organization and for drafting a constitution were Drs. John Stearns, Bliss, John Watson, Griscom, Drake, Reese, Purdy, J. R. Wood, and Tomes. On the 7th of January, 1847, at the Lyceum Hall, this committee reported a constitution, which was adopted, and a complete organization of the New York Academy of Medicine was effected. Dr. John Stearns was elected the first President. The Academy is divided into six Sections, viz. 1. A Section of Anatomy and Physiology; 2. Of Surgery; 3. Theory and Practice of Medicine; 4. Obstetrics and Diseases of Women and Children; 5. Chemistry, Pharmacy, Materia Medica, and Botany; 6. Public Health and Legal Medicine. Each Section makes quarterly reports, and some of them may almost be considered separate organizations, especially the Surgical and Obstetrical Sections.

Since the primary organization of the Academy it has been reorganized twice. The original constitution adopted by the committee originated with Dr. Reese. The present objects of the Academy, as recorded, are:—

1. The Cultivation of the Science of Medicine.
2. The Advancement of the Character and Honor of the Profession.
3. The Elevation of the Standard of Medical Education.
4. The Promotion of the Public Health.

This Society has published its transactions at irregular intervals since its organization; in which are to be found many valuable papers—the one deserving particular notice is that of Dr. C. E. Isaacs, on the Minute Anatomy of the Kidney.

In 1848, "The Society for Medical Inquiry" was organized by Drs. J. P. Batchelder, F. U. Johnston, S. Conant Foster, J. O. Stone, William H. Van Buren, J. P. Garish, and S. S. Purple.

This organization is social in its character. Its membership is limited, and its meetings are held at the houses of its members.

At the invitation of Dr. J. O. Pond, in January, 1849, there met at the house of Dr. Pond, Drs. Joel Foster, J. Van Pelt, J. Hubbard, and J. J. Clements, and organized the "New York Medical Association," with "the object of mutual improvement in medical knowledge and a more intimate social intercourse." Dr. Pond was elected the first President of the Society. No Transactions of the Society have ever been published. Eating, drinking, and smoking are strictly prohibited at the meetings of this Society, which are held at the houses of its members.

In May, 1859, Drs. R. Nelson, T. and P. Dewees, J. H. Douglas, John O. Bronson, Horace Green, A. K. Gardner, John W. Corson, J. W. Richards, Charles Brueninghausen, E. R. Peaslee, Joseph Worster, and Joseph Martin, met and organized the Medico-Chirurgical College of New York. This Society was organized with the avowed object, "The Promotion of Medicine and Surgery and the branches of Science allied therewith." It is composed of resident, non-resident, and honorary Fellows. It recognises the code of ethics of the American Medical Association. It meets semi-monthly at the houses of its members. A chairman is chosen every meeting, instead of having a permanent President. Papers of value have been issued under its auspices, and preparations are being made for a regular issue of its proceedings. Present number of members, twenty-five.

Turning to the records of our own Society, I find that in the autumn of 1853, Drs. Elsworth, Elliot, E. Lee Jones, F. Elliot, Stephen Smith, and O. P. Stall, met at the office of Dr. E. Elliot, and organized the "New York Medical Union," with the motto, "in union there is strength." The object of the organization was improvement in the Science of Medicine and General Literature, by the presentation of papers on any matter connected with medical or scientific subjects: the narration of cases; the exhibition of specimens, instruments, and books, with such discussions as may arise. Dr. Elsworth Elliot was the first President. Its membership has been confined to the younger members of the profession. Original papers read before the Society have been published in the medical journals of the city. In 1854, a periodical Book-Club originated—the journals, after being read by the members, becoming the property of the Society. Our present number of members is twenty.

Medical News.

DEATHS.

Jones—At Baldwinsville, Onondaga co., N. Y., on Friday, March 29, Daniel T. Jones, M.D. Dr. Jones was an eminent citizen of Central New York; he served two terms in Congress from Onondaga county; was President of the State Medical Society in 1860; and has occupied various important positions.

University of Maryland.—The fifty-fourth annual commencement of the Medical Department was held by authority of the Provost and Board of Regents, on Saturday, March 2. Professor Miltenberger, Dean, read the mandamus; Professor Smith conferred the degree of M.D. upon sixty-three graduates, and presented their diplomas. Prof. Hammond delivered the Valedictory Address to the graduates.

Savannah Medical College.—This school held its commencement on the 1st of March, when fourteen graduates received diplomas.

Original Lectures.

LECTURES ON DIPHTHERIA.

DELIVERED IN THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

BY

A. CLARK, M.D.,

PROFESSOR OF PATHOLOGY AND PRACTICE OF MEDICINE.

Lecture II. Part II.

Diphtheria with typhoid fever.—Symptoms reviewed, vomiting in the advanced stages a bad symptom.—Membrane, the time of its occurrence, its recurrence, its color.—Convulsions as an early symptom.—Pulse frequent, infrequent, and irregular; the irregular the gravest prognostic.—The soreness of the throat often inconsiderable.—Aphonia not constant in tracheal diphtheria.—Croupy cough almost but not absolutely constant.—Delirium.—Fœtid breath not a common symptom.—Diarrhœa a bad symptom.—Albuminuria.—Tumefaction of the fauces causes dyspnœa.—Coma.—The disease probably communicable, Bretonneau's doctrine of literal contagion not generally adopted.

Among the specimens of diphtheria exhibited to you the present session, you will remember the tonsils, uvula, larynx, trachea, and fine divisions of the bronchial tubes of an adult lined by false membrane. The patient from whom the specimen was taken had been suffering from typhoid fever for two weeks at the New York Hospital, when he was attacked with symptoms of croup, and died in a few days, tracheotomy having been unsuccessfully performed. Several cases of a similar character were seen at the same hospital during the epidemic of typhus some years ago, in patients affected by that disease. It seems to have occurred in these cases after the completion of the second week of the fever. M. Louis (Arch. Gen. de Med., tom. iv., 1824) has reported two cases of membranous exudation in the air-passages, and the usual symptoms of diphtheria in patients having typhoid fever. One was a person twenty-three years old, who had been fourteen days in the hospital before the symptoms of the membranous disease began. The other was in a boy aged fifteen years. Dr. Greenhow (On Diphtheria, p. 76) reports that Dr. Heslop, of Birmingham, found in Nov., 1858, that of four cases of typhus fever occurring in one house, two of the patients had membranous exudation in the throat. In one of these it is stated that the patient, a girl aged seven years, had suffered nearly a fortnight before the appearance of the throat affection. In the other case the time of the occurrence of the latter is not mentioned. M. Louis's cases are described under the title, croup in adults; but as diphtheria was prevailing in Paris at the same time, it is more reasonable to refer them to this class.

Thus, gentlemen, from these cases and statements, you may form some idea of the length and breadth of the influence of this disease.

I shall now call your attention again to the symptoms, and enlarge a little upon some that have been already referred to, and speak of one or two that have not yet been named. I have told you that *vomiting* is not unfrequently an early symptom; as an early symptom, it is not of very great importance. It occurs also frequently in the latter part of the disease, and then it is not unfrequently of considerable moment, as it interferes with the regular administration of the means on which you have relied for recovery. As a rule, children vomit easily, and they are less exhausted than adults; yet it is an unfavorable symptom, inconvenient in every respect, and exhausting even in them. Its disastrous influences may be better appreciated if I give you a synopsis of a case of Dr. Thayer, as recited in the excellent paper in the first number of the *Berkshire Medical Journal*, just issued. In 1857, a patient thirteen years of age had very moderate diphtheritic inflammation of the fauces. Partial improvement nine days after attack; rode to doctor's office on the fifteenth day; again confined to house; soon to her bed; the throat but moderately swollen, but the false membrane continued; vomited daily, with daily increasing weakness; at length very restless, and on the twenty-fifth day in her uneasiness got out of bed, and died of syncope a few minutes after. She had had no hemorrhage, and no laryngeal diphtheria, but the vomiting could not be controlled, and she grew weaker and weaker under its influence.

It was but yesterday, in the practice of Dr. Blakeman, that a child about five years old, that had been suffering for about a fortnight with diphtheria of the fauces, without any alarming symptoms, began to vomit. The vomiting was not readily controlled. No food or medicine could be retained. We resorted to nutritive injections, but last night she sank into a kind of syncope and died. There was no dyspnœa, no hemorrhage, and yesterday morning no alarming frequency or irregularity of the pulse.

In regard to *the time of the occurrence of the membrane*, this varies exceedingly in different cases; in general it appears on the second or third day of the febrile movement, when there is a febrile movement; but in other instances it will be delayed to the fourth, fifth, and sometimes as late as the tenth or fourteenth day, there being a little febrile action all this time. Such a case I saw quite lately in a lady forty-five years of age, the wife of a physician. For nearly fourteen days she had suffered from sore throat, that annoyed her very much, altering her voice considerably. At the end of that time the membrane formed for the first time upon the epiglottis, making a sort of glove or cap for it. It was arrested, however, at this point, and did nothing more than put her to a great deal of inconvenience and alarm. She recovered readily.

The *disposition of this membrane to recur* is one of the most striking things in its history. It will be renewed two, three, or four times in the first ten to twenty days, and as it is reproduced, often extending. At other times you will see it exfoliate, and show no disposition to return whatever. If it were possible to fix a period of average duration, I think it would vary little from ten days. *The color of the membrane* is very variable. Often at the beginning it is of snowy whiteness, or in thin layers translucent; as it increases it assumes a yellowish hue, or an ash color, or if blood or ferruginous medicines are incorporated with it, it becomes of a dark hue, often quite black. Often the patches on the tonsils are surrounded by a very marked deep red circle, and the membrane appears depressed in consequence of some swelling in this red zone. When portions of the membrane separate from portions that are still attached, it has a shreddy, sloughy look, resembling loose cotton saturated with pus, and is commonly of a light grey color or of a dirty yellow.

In a few cases *convulsions* are an early symptom. I have already told you that convulsions not unfrequently terminate this disease; but they occasionally occur as one of the earlier symptoms. I have the minutes here of a case in which they occurred in a child four or five years old, two children in the same family being seized with diphtheria at the same time. The symptoms were almost exactly analogous, except that the younger child, in whom the disease proved fatal, was sleepy for two or three days before any membrane was noticed in the throat, but was very bright afterwards. He died of tracheal diphtheria. The other child, seized at the same time, had the same degree of fever, had convulsions two or three in succession, but had only a local inflammation, that is to say, membrane appeared upon the tonsils, exfoliated in two days, reappeared three days afterwards, was threatening for a time, but did not descend into the larynx nor ascend into the nares, and she recovered. Dr. Kneeland, in the *American Medical Times*, reports two cases where the disease was attended by convulsions in the beginning. They had not occurred before in any of these children. It does not

appear, from the few cases reported, that convulsions are very alarming in the earlier period of the disease, but at the conclusion they are of the utmost importance.

The pulse is interesting. Usually in the beginning of the disease it is rapid, in the child, 120 to 140, supposing the invasion to be decided. In the insidious cases we have but little means of knowing what the pulse may be, because our attention is not then called to it. As the disease advances, there are three things specially noticeable in the pulse. In some it continues at a pretty rapid rate during the whole of the disease; in others it is rapid for a certain time, and then almost suddenly falls off to some small number, 56, 50, 40 even, and remains there, without any cause that we can distinctly ascertain, for three or four days; and in others still its striking feature is extraordinary irregularity—rapid, interrupted, and irregular in all respects. Among these peculiarities I think I have learned to regard the irregular pulse in the advanced periods as of the gravest importance. A rapid pulse can be borne for a considerable time, and still a child may recover; and the infrequent pulse, as I have met it, is not among the most alarming of the prognostics; but a markedly irregular one is that which gives me the gravest anxiety. I know of no one symptom, the difficult breathing alone excepted, that is more indicative of an unfavorable issue.

A circumstance that will early attract your attention is that while there is much inflammation of the throat the patient makes but *little complaint of soreness*. There seems to be in these parts in certain cases a sort of local anæsthesia, whether muscular paralysis exists or not. A physician, about thirty-five years of age, felt the first symptoms of illness, of an afternoon in his carriage, while performing his usual round of duty. He soon had a severe chill, followed by high fever. This was interrupted by another chill, which in its turn had its fever, and before the evening he had still a third chill, followed by heat—all the time headache, vomiting, prostration. I saw him the next morning. His pulse was then 140; his face flushed and almost turgid. He had no soreness of throat, he said; but the tone of his voice announced swollen tonsils and an inflamed palate, and his febrile symptoms led me to the conviction that he had diphtheria. Patches of false membrane as large as a dime were found on each tonsil, while the external glands of the neck were moderately swollen—yet this case, so vigorous in its onset, was mild in its progress. He took tincture of iron without any application to the throat, unless perhaps he used a gargle of chlorate of potassa. In two days the membrane disappeared, and in one day more he resumed his professional labors. It happens, perhaps, in one-half the cases that no complaint is made of sore-throat, and there is no great difficulty experienced in deglutition; but there is often in children an extreme unwillingness to make an attempt to swallow.

It is worthy of notice, also, that *the voice* in tracheal diphtheria does not seem so uniformly affected as in croup, or rather it does not seem to be affected to the same extent. A great many children who are actually suffocating with this disease, from the embarrassment to the respiration, can speak aloud; some again can only whisper. *The croupy cough* is almost a constant symptom in tracheal diphtheria, occurring as it does in ordinary croup and from a similar cause; still Dr. Gottschalk reports two cases shown to be membranous disease by dissection after death, fatal from suffocation, in which the peculiar barking cough was not present at any time.

The condition of the *mind* is a point of some interest. In many of the children, no matter what characters this disease may take, the mind remains sound to the end; in others there is pretty active *delirium* during the middle stages of the disease; and still in others at the end there is coma; it occurred in the case that I just now referred to, recorded by Dr. Buck. In adults delirium is sometimes the most prominent of the symptoms. This was very marked in the father of the affected family at Elizabeth. While his children were sick with scarlet fever and diphtheria, he suffered from diphtheria with but moderate febrile excitement; delirium commenced early in the disease, and continued until the throat symptoms began to subside. *Somnolence* is not an unfrequent occurrence in the early and middle periods.

You hear a good deal about the *fœtid breath* of diphtheria. It is not by any means a constant occurrence; you will perhaps see ten cases before you find one in whom this peculiar odor of the breath is very striking; when you perceive it, it will be decided. It has been ascribed to the decomposition of the false membranous matter that has been produced during the disease; but this is not all. I saw, for example, only a few days ago, a gentleman who had had diphtheria, and in whom the membrane had all disappeared; only a cough remained over, and his breath was so fœtid that his physician was fearing gangrene of the lungs. It was for the purpose of discovering whether gangrene existed that I was invited to see him. I could, however, find none; there was nothing but that peculiar fœtor that is occasionally noticed in fœtid bronchitis. It seems to be the result of a morbid secretion from the mucous membrane. But remember, you are not to expect its occurrence very often. I was led to suppose, in reading of this disease, that fœtid breath was almost its diagnostic mark.

Diarrhœa.—This is occasionally noticed as a complication, and it is often a very grave one. Diarrhœa occurring in the latter part of the disease, is more apt to present itself in those who are already debilitated, and will sometimes be the immediate cause of death. It is therefore desirable that it receives early attention, coming on at this period.

Albuminuria.—I find, on examining my own notes, that the question of the existence of albumen in the urine was one that occupied my attention early in the epidemic. I am able to give you nothing more in regard to it than has been already written; it does occur in a moderate proportion of cases, and as yet no one has ascertained what is its significance. Cases in which albuminuria has been observed get well as others do.

The *swelling of the fauces is occasionally noticed as a cause of great embarrassment in the breathing* where the larynx and trachea are entirely free. This was remarkably true in the case of the gentleman at Elizabeth just referred to. His breathing was difficult and noisy when awake, but sleep for two or three days at the height of his disease, seemed to be impossible. The moment he lost himself the inspiration was interrupted, and after three or four unsuccessful efforts to effect it he would wake partially suffocated and alarmed. Expiration was not difficult. This seemed to arise from the relaxation of the swollen tissues of the fauces consequent upon sleep, these falling upon the larynx so as to stop the opening of the glottis. An embarrassment arising from a similar condition had been noticed in many other cases.

Coma, as you have been already told, is occasionally a termination of diphtheria, and it is a question yet to be decided whether that coma is the result of uræmia or not. In a word, here is a point in the symptomatology of the disease which has been very inadequately investigated, and I commend it to you as the subject of particular study, and indeed the whole subject of albuminuria in diphtheria.

I will delay you to-day a few minutes longer to consider one question more regarding diphtheria. Is it *contagious?* I have here rather copious notes from the authorities regarding this matter, and will recite to you the substance of them. Bretonneau, who is the first and principal authority in regard to most questions that are now agitated regarding diphtheria, entertains no manner of doubt of its communicability. He assumes that diphtheria was imported into Greece by numerous Egyptian colonists, and was known there as the Egyptian disease; and that the time at which this importation occurred was nearer to that of Homer than that of Hippocrates. I am sure I cannot tell from what authority he has derived this statement, but I believe it is very generally conceded by those who have looked into the chronology of

diphtheria, that the first clear indication of it is given by Aretæus. I know from my own research that he does not intimate how long it had been known. I am therefore disposed to assume that there is in this assertion something of that straining after effect, for which Bretonneau may sometimes be justly blamed. The diphtheria is undoubtedly the Egyptian or Syriac ulcer of Aretæus, but when and how it was introduced, I do not know that we have any evidence whatever. "The land of Egypt," says Aretæus (Adams's translation), "especially engenders it, the air thereof being dry for respiration, and the food diversified, consisting of roots, herbs of many kinds, acrid seeds and thick drink, viz. water of the Nile, and a sort of ale prepared from barley. Syria also and more especially Cœlo-Syria engenders these diseases, and hence they have been named Egyptian and Syriac ulcers." The assumption that it was brought from Egypt into Greece implies its contagiousness. Bretonneau is convinced that it is communicable from person to person by contact, as syphilis is; and he gives several instances mostly from the observations of Trousseau and Ramon, of its being communicated by direct inoculation. The following is one of his cases:—At the Ecole Militaire, in 1826, four pupils and one sister of charity had died. A pupil having excoriated chilblains, wetted his foot in a little pool of sputa at the bedside of one of the first patients. An excessively painful ulceration was the consequence; it was established between the toes, and was covered with false membrane. The Egyptian disease thus inoculated, yielded only to the employment of a solution of nitrate of silver, and after to the "soothing and cicatrizing action of calomel." In the table relating to cutaneous diphtheria given in the first lecture, an instance is referred to in which Trousseau and Ramon saw a woman who had contracted diphtheria of the nipple from suckling an infant who had buccal diphtheria. The inflammation in the mother extended to the breast with the production of false membrane, and exceedingly painful swelling.

Several instances are recorded in which physicians either in examining the throat of patients, or in performing tracheotomy, have been sprinkled with this secretion by the coughing of the patient and have afterwards suffered from the disease.

Bretonneau publishes the case of Dr. Herpin, Surgeon of the Hospital of Tours, as follows:—"I attended," says Herpin, "a child with pharyngeal diphtheria in angina, which had become croupal. It yielded to energetic cauterization with solution of nitrate of silver, frequently repeated for six days. A nurse, who took care of the child, was attacked with pharyngeal diphtheria, which soon yielded to local treatment. The child being intractable coughed and violently threw out the sputa. The orifice of my left nostril once received some of this excretion, but from being obliged to continue the cauterization, I had no time either to wash or wipe the part. A few days afterwards, there was snuffling on the left side, and nasal voice, then suddenly painful pharyngeal angina, sleeplessness at night, extreme uneasiness, weakness, coldness, and pain. In the morning both tonsils and the uvula were completely enveloped in a white incrustation. Three times a thimble of false membrane enveloping the uvula was detached and reproduced. Deglutition difficult, sputa abundant and fetid; stools loaded with false membranes," etc.

Bretonneau also gives the following:—"A short time after the inoculation of nasal diphtheria under which Dr. Herpin nearly sank, my friend, Dr. Gendron, of Château du Loire, being obliged to perform tracheotomy, received on his lips, at the moment of opening the air tube, a shower of tracheal exudation thrown out by a convulsive fit of coughing. Pharyngeal diphtheria was the immediate effect of this accident. Originating on one tonsil the special phlegmasia so rapidly reached the larynx that I was obliged to have recourse to energetic treatment. The cure was rapid and complete, and none of the symptoms of constitutional diphtheria were developed."

Within a few days it has been announced that Dr. Gendron, of Tours, perhaps the same physician referred to in the last case, had died of this disease, having had his face covered with the secretions from the throat of a woman suffering with diphtheria, during tracheotomy. This certainly looks like contagion. It is not a year since, that Baltimore has had occasion to lament the death of a distinguished and learned physician, whose disease *seemed* to be acquired during the performance of the same operation. Soon after performing tracheotomy for diphtheria, Dr. Frick began to suffer from sore throat, which terminated in membranous disease of the larynx. Tracheotomy was performed, but it was unavailing, and he died. It does not appear that in his case there was any actual contact of the diseased secretions with any of his mucous surfaces.

In opposition to this opinion of Bretonneau, "that true inoculation is the only mode of transmitting the Egyptian disease," we have to remark the complete failure of the attempts which have been made to produce this affection by the application of the morbid products to the tissues of men and animals. Both Bretonneau and Trousseau have attempted to inoculate their own throats with this disease, and have both failed; the latter made one puncture on his arm, and five or six on the velum pendulum palati. On the arm a vesicle was produced, but no result on the mucous membrane. Quite recently Dr. Peter of the Children's Hospital in Paris, has added his own personal experience in inoculation, and like Bretonneau and Trousseau, failed to produce any specific disease.

Instances are reported by Greenhow of attempts to inoculate the inferior animals, all of which were unsuccessful. Bretonneau says, "I have made some ineffectual attempts to communicate diphtheria to animals."

Most of the later French and English authorities agree with Bretonneau in the general fact that the disease is communicable, but very few assent to his doctrine of exclusive and literal contagion. The facts usually cited as evidence of contagion are—the disposition of diphtheria to spread in families when it has occurred in one member; the spread of the disease in hospitals from bed to bed, and its disposition to confine itself to particular wards; its production in families and places previously healthy, as the sequence of the introduction of persons from infected families and places who have fallen sick at their new residence. On the other hand it is well known that the disease is often confined to one person, though surrounded by those who are believed to be liable to it; and it is well known that outside epidemic influences often simulate very closely the effects of contagion. I suppose we shall be obliged to sum up the matter in a few words, and say that the strength of the argument is upon the side of contagion. My own observation has given me but limited opportunities of observing its communicability. I believe, however, we should not be justified did we not take certain precautions in the chance that it might be communicated. It will doubtless take a good while to settle the question satisfactorily; it has taken a long time to determine whether typhoid fever, scarlet fever, and measles were communicable, and it took a great while to determine that yellow fever was not communicable. In the meanwhile my conviction is that it is our duty to remove healthy children from those that are infected, and also to forbid the use of table furniture and linen appropriated to the sick by any other members of the family; and not to use a spoon or other instrument, with which the tongue of a diphtheritic child has been depressed, for the same purpose in another child, until it has been thoroughly cleansed.

Domestic Items.—Prof. Flint has returned to New York, and is now giving a course of lectures in the Long Island College Hospital.—Prof. Flint, Jr., has gone to Europe to pursue physiological studies.—Dr. Juriah Harris, editor of the Savannah Journal of Medicine, has retired from that position.—Prof. N. A. Pratt, of the Savannah Medical College, has resigned.

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